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MANIFESTATIONS OF THYROID DISEASE IN THE UPPER RESPIRATORY TRACT.*

BY BURT R. SHURLY, M. D., DETROIT, MICH.

A search of the literature on thyroid disease during the last decade reveals a voluminous and interesting record of observations and investigations from all the departments of medical science, except laryngology. The meager contributions from our particular branch call for an explanation. Can it be true that in most communities, the neurologist, the surgeon, the internist, and the ophthalmologist, claim these cases exclusively and consider observations of the laryngologist as immaterial and without a scientific suggestion that is worth the trouble? If this suspicion be correct the fault is with the laryngologist who fails to find symptoms and lesions sufficient to prove his interest and value in the case.

The phenomena of the various forms of thyroid disease are so extensive that the majority of specialists may lay a claim for consideration, but in my experience, the greater number of these city patients, will refer their symptoms to the throat or eye and seek advice accordingly.

The cases of impaired function that particularly interest us are the numerous varieties of atypical forms of Graves' disease and myxedema that occur between the extreme manifestations of these disorders. Hyperthyroidism or Graves' disease and so-called atrophic thyroiditis, or myxedema, present distinct and definite diagnostic signs for classification, yet in the modified or atypical forms they interchange and the same patient may exhibit at the same time

*Read before the meeting of the American Academy of Ophthalmology and Oto-Laryngology, Cincinnati, September 19-21, 1910.

a well-defined Graves' disease with marked myxedematous symptoms.

Before discussing this problem from our special point of view it may be well to enumerate the general diagnostic signs according to the classification of Beebe and Rogers.

CLASSIFICATION.

HYPERTHYROIDISM—More common in young women of 18-30 years.

Onset—May be slow and gradual or sudden and acute.

Tachycardia—120-180; pounding beat felt over a wide area; often a loud systolic murmur over apex, base, and along the great vessels. Irregular from, and very susceptible to the effects of exercise. Blood-pressure variable, generally low, pulse soft and full, marked dyspnea on slight exertion. Marked edema of the legs.

Nervous System—Fine tremor affecting nearly all the muscles, twitching and occasional spasms. Patients are abnormally irritable and excitable; apprehensive, mentally very active and physically restless. Muscular weakness prominent.

Eye Signs—Exophthalmos generally present, although it is not invariable. Occasionally unitateral, corresponding to the side having the enlarged thyroid lobe. Various symptoms arise in consequence of the exophthalmos. No pupillary changes.

Gland—Enlargement varies from nothing to very large goiter. The blood-vessels over the gland are generally much enlarged and pulsate markedly. Right lobe generally the larger.

Nutrition—Severely disturbed; in most cases there is a loss in weight, which may progress to extreme emaciation. Appetite variable; vomiting and diarrhea frequent complications. Patients drink a great deal of water.

Skin—Profuse perspiration, erythema, urticaria, dermatographia, pigmentation, which may occasionally be so marked as to suggest Addison's disease. Hair falls out, but is not coarse and dry. Patients prefer thin clothing and cold rooms. They are more comfortable during cold weather than during hot weather.

Temperature—May be only slightly elevated. 99°-100°. With severe acute cases it runs often to 103°-104°.

Urinary Findings—In most cases normal in volume; glycosuria not unusual; polyuria often observed in later stages. Nitrogen partitions show a very much decreased creatinin excretion, while creatin is present in large amounts. Nitrogen loss is marked during the period of emaciation.

Blood—Hemoglobin low, leucopenia in severe cases, with a marked relative lymphocytosis.

Menses—Very irregular or completely suppressed.

HYPERTHYROIDISM—More common in advancing years, 35-50.

Onset—Slow and gradual, in many cases engrafted on an old Graves' disease.

Heart—Rarely above 100, may be irregular with heaving impulse. Pulse generally shows high tension and the blood-pressure is above normal.

Nervous System—Patient may have some tremor and muscular weakness is likely to be very pronounced, but there is not the same restlessness and jactitation. Patients are occasionally irritable, but they are generally dull and apathetic, mentally slow; memory defective. Pains in joints frequent, and referred to as rheumatism; there is a marked tendency toward sudden giving way of the legs when walking.

Eye Signs—Exophthalmos is unusual, although it may have been present at one time.

Gland—Often no enlargement can be made out; when there is a goiter, it has an elastic rubber-like consistence occasionally cystic and nodular, but very distinctly differing from the active pulsating gland of Graves' disease.

Nutrition—Generally not seriously disturbed; patients hold their weight and in most cases gain slowly; constipation rather than diarrhea, and flatulency a troublesome habit. Patients do not drink much water.

Skin—Dry, may be scaly; patients do not perspire on exertion; hair and nails dry and brittle; scalp scaly. Pigmentation not common. Patients prefer thick, warm clothing and are cold most of the time. Much more comfortable during hot weather.

Temperature—Subnormal, may reach as low as 95°.

Urinary Findings—Albuminuria not unusual. Nitrogen partitions do not show so marked a disturbance in creatinin and creatin ratios. In large number of cases urine practically normal.

Blood—Hemoglobin low, white blood-count normal.

Menses—Generally regular but scanty.

We note in addition to this classification that the development of Graves' disease is influenced by the hereditary history of thyroid, heart and nervous diseases; that it follows most frequently from fright, strain, over-work, nervous shock, or infectious disease. It

is interesting to observe that the hyper-function of the thyroid is in no relation to the size of the goiter.

Capille has observed that in seventy-nine per cent. of exophthalmic goiters that came to autopsy, the thymus was enlarged. This is of diagnostic importance as thymus cases are attended by enlargement of the tonsils, spleen, and follicular glands of the tongue. The dangers of surgical intervention are greatly increased in these cases. Two cases of myxedema reported by Theisen and E. L. Shurly originated from the removal of an accessory thyroid in the region of the lingual tonsil and which gave the appearance of benign tumors in this location.

It is a well-recognized fact that the faucial tonsils are in definite physiological and pathological inter-relation with the thyroid gland. It is fair presumptive evidence that a tonsillar internal secretion exists which affects the governing action when we find that a series of enlarged thyroids will subside after complete enucleation of the tonsil. We know that septic processes such as tonsillitis, quinsy, scarlet fever, measles, typhoid fever, and influenza, that attack particularly the lymphoid tissues are frequently direct etiological factors in the development of exophthalmic goiter. Indirectly then it may be argued and demonstrated that tonsillectomy has a place in the prophylactic treatment of Graves' disease.

Tonsillectomy however, has proved of little material value in prevention. It is necessary to wait at least a decade before a collective investigation can define the true influence of the complete enucleation operation upon the thyroid in particular, and the system in general.

The effects of thyroid toxemia and deficiency are so profound upon the nervous, muscular and circulatory systems, that it is logical to expect a majority of these cases will present special manifestations in the upper respiratory tract. The unstable vaso-motor system especially renders the subject liable to annoying symptoms in the nose, throat and ears.

In the moderate or severe myxedematous forms we notice defects or changes in speech in many cases. We also find varying degrees of slowness and difficulty in articulation. The voice at intervals becomes husky or thick and the mucous membrane of the larynx, pharynx, tongue, mouth and lips becomes swollen and dry through deficient lubrication. The change in the voice may be associated with a motor insufficiency of the laryngeal muscles. Matthews, of Rochester, Minn., has reported two hundred and eighty-

nine cases of laryngeal paralysis in one thousand cases of goiter; seventeen of these were bilateral. Although my experience is limited, it would seem as if slight motor insufficiency had been classified as paralysis. In the majority of his cases of goiter the frequency of pressure-symptoms is in proportion to the size of the goiter.

In myxedema, however, the goiter is usually small, and the change in voice will be out of all proportion to laryngoscopic findings. Again a considerable paresis may be attended by little or no change in voice. Impairment or perversion of taste is occasionally prominent. Howard in a carefully studied series of thirty-two cases found six with abnormal taste. Hun and Prudden report thirty-three per cent as deficient in taste.

Two of my cases presented themselves for treatment—suffering from a most distressing tinnitus aurium. The symptom was so annoying that sleep was obtained with difficulty. The aural examination was completely negative and relief was obtained by general treatment. Some observers report impaired hearing in seventy-eight per cent of cases. It is difficult to explain whether this is due to hyperemia and swelling of the auditory nerve, trophic changes, or some direct vaso-motor change.

In Graves' disease, taste, smell, and hearing are more rarely affected. In severe myxedema, hemorrhages, from the gums, nose, or throat are common, although unusual in the atypical forms. The patient may consult the laryngologist, complaining of dyspnea on slight exertion; when a careful examination may reveal no physical signs of pulmonary disease. This symptom is often associated with falling hair, brittle nails, dry skin, and other phenomena of early atypical myxedema, which will respond to treatment by thyroid feeding or the administration of iodine or phosphorus. Dyspnea in Graves' disease is a late symptom—usually associated with myocardial or other cardiac change, and may be attended by a limitation of the expansion of the chest. Acidosis and a "fruity breath" may attend this phenomenon.

I have occasionally observed with Lemm, Curtis and others that a peculiar infiltration of the nasal mucous membrane may occur in myxedema as one of the early signs; and later the membrane becomes thickened, and the nose obstructed by a gelatinous, waxy, or yellowish, secretion. Some of these patients complain of a full, cramped or swollen feeling in the throat. The changes in coloring may be transmitted to the pharynx and larynx. It may be pale,

yellowship, or have a bluish tinge. The uvula may be elongated, or angio-neurotic phenomena may appear. The inter-arytenoid fold may be transparent. No change in function of the vocal cords is usually seen.

The symptoms of cough may bring the patient to the laryngologist when associated with Graves' disease. It may be attended by a dry throat and husky voice. In several of my cases this was the predominating and annoying symptom uppermost in the mind of the individual. The temperature, cough, precordial pain, unilateral bruit, and loss of weight had been sufficient in a number of my cases to lead the attending physician into a diagnosis of suspected pulmonary tuberculosis; others were sent to me by members of the family under the same apprehension. Bronchial and pulmonary hyperemia are exceedingly common in Graves' disease.

The cough may be associated with intra-laryngeal pressure from a hard swollen goiter. In this condition the amount of cough may change either with position, diminish or increase with the consistency of the gland. The myxedematous forms more rarely cause cough, although slight pathology in the upper respiratory passages is attended by symptoms out of proportion to the lesions. This may be explained on the basis of the abnormal psychic condition of the individual.

A disease like exophthalmic goiter that passes through many intervals of quiescence and exacerbation must necessarily exhibit a long list of remedies for which great curative value is claimed. The great majority of drugs are useless except when occasionally indicated for the control of special symptoms. The therapeutic measures which I have adopted in this series of thirty cases are those selected by elimination. Rest is certainly essential to success.

A considerable advantage may be obtained from the proper use of the galvanic current. A small (anode) electrode should be applied along the cervical sympathetic. The cathode, should be larger, sponge applied to the neck, along the lower cervical vertebrae, beginning with a one milliampere current and later gradually increasing the dose.

In a number of cases a sedative effect may be noted upon the cervical sympathetic and general nervous system. The dry and swollen mucous membranes are best relieved by the use of lecithin or phosphorus. Soda phosphate in carefully directed dosage is often of great service. Many of the cases combined with myxo-

matous symptoms improve under the administration of pure iodine, especially by the hypodermic method. The X-ray may be of value.

Six cases were treated with the Beebe and Rogers serum with striking improvement. Three of these patients may be classified as complete recoveries. Two of the thirty patients, one of whom died the following day, were operated by general surgeons. Immediate operation was advised in another that died from pressure suddenly ten days later, untreated. The question of surgical interference is exceedingly important. A study of the individual case alone can definitely determine this problem. Medical treatment without improvement should not be prolonged. When surgery is considered necessary the choice of the surgeon is of paramount importance. The best technicians have from one to five per cent mortality.

In myxedema and especially in the atypical, great relief and lasting benefit is attained by the administration of thyroid extract in the carefully selected dosage of carefully selected preparations. The results of this substitution therapy are among the greatest achievement of modern science.

It is evident that the rôle of the internal secretions as governors and regulators of harmony in the functions of the upper air tract is important and significant. It is demonstrable that the tonsils and thyroid are concerned in some delicate and complex influence upon each other and that a wide inter-relationship exists among the ductless glands. These mysteries of bio-chemistry are being unraveled. Meanwhile the clinical observer must stand by and report the signs and symptoms as they appear to him, and apply his treatment according to his most modern conceptions.

In view of the numerous symptoms and conditions of Graves' disease and myxedema with the intermediate forms that are referred to the nose, throat, and ear, it would seem to me within the rules of modesty to respectfully suggest to the internist and surgeon that his case had not been completely examined until the laryngologist and otologist had added his diminutive, but sometimes important contribution to the general information.

32 West Adams Avenue.

BONE CYST OF THE ETHMOID CELLS.

JOHN A. THOMPSON, M. D., CINCINNATI.

Mrs. M., of Washington, Ind., was referred to me by her family physician, October 18, 1910. The only subjective symptom in the case was the complaint of a very profuse serous discharge from the right nostril when she stooped. With the exception of this one complaint, she was an unusually healthy and robust example of middle-aged womanhood. She had been annoyed by this discharge for several months. Previous treatment, local and general had brought no relief. Inspection of the nose showed the changes of atrophic rhinitis. There was a perforation in the anterior portion of the septum nasi. Nothing could be seen to indicate the source of the discharge. Transillumination of the accessory sinuses showed them to be unusually clear. There had never been any pain or headache. Careful exploration of the right outer nasal wall with a probe showed carious bone in the wall of the bulla ethmoidalis. Curetting away this diseased bone, I found a small opening in the top of the bulla from which the discharge escaped when the patient leaned forward. The dividing walls of the ethmoid cells had all been destroyed, making one cavity in the right lateral mass of the ethmoid bone. This cavity was lined by a thin, white glistening membrane, the typical cyst lining in appearance. This membrane was curetted lightly. I feared breaking through into the orbit or cranial cavity if an attempt were made to remove the membrane thoroughly, as the bony walls were so thin they apparently yielded to slight pressure. The cavity was packed for twenty-four hours to control hemorrhage and then the packing was removed and the patient returned to her home.

One month later the patient returned, saying that the only change was that the discharge was continuous now, while before it occurred only when she stooped. Inspection of the nose showed a free opening into the cyst. Fully two-thirds of the cavity was covered with normal membrane. She was advised to return home for another month and told if the discharge did not cease in that time I would remove the secreting membrane. Nothing more was heard from her for six weeks when she wrote that she was entirely well and thought another visit was unnecessary. I can recall no similar case in my practice, and remember none being described in the recent literature of rhinology. It was as difficult a case in which to make a correct diagnosis as any I have ever treated. It is reported to help any of my colleagues who may meet a similar puzzling condition.

628 Elm Street.

REPORT OF A CASE OF SARCOMA OF THE TONSIL IN A YOUNG CHILD.*

BY L. C. CLINE, M. D., INDIANAPOLIS, IND.

On December 19, 1910, Mrs. C. M., with her little boy, 22 months old, came to consult me in regard to the son. The child had never been very sick until two months prior to the visit, when it had what was thought to be a tonsillitis, which developed two weeks later into a tonsillar abscess. The abscess ruptured and a considerable amount of purulent fluid discharged. The child had had some fever at times. In the main, it was well-nourished, but during the last week it had developed great difficulty in breathing in the recumbent position.

On examination I found a nodular growth involving the left tonsil, almost filling the pharynx. It was rather soft to the touch and bled profusely on pressure. The mother stated that ten days previous, there had been a swelling under the angle of the jaw which had somewhat subsided under poulticing. Several enlarged lymph-glands could be felt under the angle of the jaw, extending down almost to the clavicle. A small portion of the tumor, sufficient for examination, was removed and placed in the hands of a pathologist—Dr. Jewett V. Reed—who reported the tumor to be a sarcoma. After a more thorough and complete examination, he gave me the following report:

"The specimen submitted measured one and a quarter inches in diameter and was about three-quarters of an inch thick with a very irregular surface. Celloidin sections were made from various parts of the mass and the microscopic examination revealed the following conditions: All of the sections show an abundance of small round sarcoma cells with very little connective tissue stroma. These cells were definitely sarcomatous being larger than the normal lymphocyte of the normal or inflamed tonsil. In several areas mitotic figures were seen in these cells, showing very active growth. Thin-walled blood-vessels were abundant and in many places the walls of these vessels were invaded by sarcoma cells. Diagnosis: Lymph-sarcoma of the tonsil."

After the nature of the growth had been determined, it was observed that the child was rapidly growing worse, becoming cyanotic when sleeping. Dr. E. W. Wales and Dr. Jewett V. Reed were asked to see the child, neither of whom gave me any encourage-

*Read before the Middle Section of the American Laryngological, Rhinological and Otological Society, Indianapolis, Ind., March 1, 1911.

ment as to operative procedure. The dyspnea became urgent and the child was sent to the hospital.

Assisted by Dr. David Ross, I removed with the cold snare all that could be forced into the loop. I then used the tonsil punch, taking all that I could by that method. To my great surprise, the hemorrhage was slight. All distress was apparently relieved. The child ate, played and slept well. Twelve days later the growth was found to be rapidly proliferating and spreading in every direction. The cervical glands were much larger. The Coleys and other serum treatments were urged, but the parents would not consent to their trial. Believing that a radical surgical operation was not promising in a child so young with so extensive a growth, I could offer nothing further but a fatal prognosis. The child was taken home, rapidly grew worse and died in two weeks.

I have never seen nor heard of sarcoma occurring at so young an age and therefore thought the case of sufficient importance to report.

Willoughby Building.

Cysts of the Antrum of Highmore. JOHN R. FLETCHER, M. D.,
Journal of Ophthalmology and Oto-Laryngology. January,
1911.

Bone cysts of the antrum develop within the alveolar process and may extend into the cavity of the antrum, of the nose and of the mouth. They differ from a divided antrum in having as a lining only two membranous layers, i. e., connective tissue and epithelial layer; the uninfected fluid contains crystals of cholestrin, and their interior does not communicate with any part of the antrum or nose in their uninfected state.

They are diagnosed by a history of long, painless development; of tumefaction in the neighborhood of the canine fossa; by crepitation upon palpating the enlargement; by puncture or withdrawal of fluid or washing out caseous masses, or by non-communication of the cavity with the nose. In the treatment it is recommended to remove the anterior wall, dissect out the lining membrane, sterilize the cavity, and fracture its various walls inward and to be kept there by suitable packing.

STEIN.

ERYSIPELAS OF THE LARYNX.*

BY D. BRYSON DELAVAN, M. D., NEW YORK.

While erysipelas of the larynx and pharynx may be more common than is generally supposed, it is not often that cases have been studied and described. The serious nature of the disease makes it desirable that the possibility of its presence should be recognized and its diagnosis and treatment understood.

The discussion of the subject is by no means new. The dictum of Hippocrates as to its prognosis, namely, "When erysipelas extends from within outward it is a favorable symptom, but when it removes from without to the internal surfaces it is a deadly one," has been confirmed by modern observation. Cornil, in his admirable thesis which appeared in the *Archives Generales de Medecines* in 1862, confirms this, for of nine cases of laryngeal erysipelas analyzed by him where the face was first attacked, seven deaths occurred, while in nine others where the exanthem preceded the skin eruption, seven recovered. Morell Mackenzie stated that he had seen four cases in the whole course of his practice and in his excellent resumé of the subject says that erysipelas of the mucous membrane of the pharynx and larynx is pathologically similar to the same malady when situated upon the skin and that it occurs either primarily or by extension from the face along the mucous tracts of the mouth, nose or ear. The causes are the same as those which give rise to it when situated upon the external parts of the body, although it has been most often observed in the course of general epidemics of the disease. On inspecting the pharynx, the appearance of the mucous membrane when affected with erysipelas differs considerably according to the form of disease which is present. The local phenomena are generally very different from those of tonsillitis but sometimes cannot be distinguished from those of simple inflammation of the part. Cornil makes three divisions of the malady, namely, first: Erysipelas with simple redness; second, erysipelas with phlyctenilae; and third, erysipelas terminating in gangrene. Erysipelas most commonly reaches the larynx from the pharynx, but the former organ may be primarily affected while the pharynx remains normal. In cases which come under the first division the diagnosis must remain doubtful except where the throat lesion is

*Read at the meeting of the Laryngological Section of the New York Academy of Medicine, March 22, 1911.

accompanied by manifestations upon the skin. Because of the infrequency of the occurrence of this affection and by reason of the gravity of the condition, the following case possesses much interest. The notes of it were supplied to me by Dr. William Armstrong, of New York.

PRIMARY ERYSIPELAS OF THE LARYNX. REPORT OF CASE.

On March 22, 1909, I was called by Dr. Wm. Armstrong of this city to see a patient, Mr. B., aged 74, who was suffering from a severe inflammation of the throat. The day before, namely, March 21, the patient was apparently perfectly well. The day was fine and he took a short motor car ride, both in the morning and in the afternoon. He complained of nothing in the evening, but his family thought that he looked somewhat fatigued. He awakened the next morning to find that he breathed with great difficulty and that he could neither phonate nor swallow. He was seen by Dr. Armstrong at 9:15 a. m., who found him dressed and sitting in a chair. His natural complexion was rather florid but on this occasion the face was of a grayish color. The patient's mouth was open and his breathing was noisy and labored. The nose was occluded. He could neither swallow nor speak. Respiration was 32; pulse 108, full and bounding.

When seen in consultation with Dr. Armstrong at 2 p. m. of the same day, the tongue was dry, swollen and coated, with a brownish-white fur. On palpation there seemed to be considerable diffuse swelling of all the soft parts of the upper anterior tissues of the neck. The sub-maxillary lymphatic glands were swollen and tender. There was pronounced edema of the soft palate, the swollen uvula lying well forward on the tongue and considerable edema of the tonsils, the post-pharyngeal wall, the lingual tonsil and over the arytenoid cartilages. All of these tissues were of a dark-red color. The vocal bands were pinkish-gray, and the interior of the larynx much congested. The epiglottis was only slightly swollen. The conditions above described appeared to be widely diffused. There was no sign present of any distinctly localized focus of inflammation and no marked indication of the threatened formation of an abscess. The general appearance of the throat, together with the other symptoms present, suggested the diagnosis of erysipelas. Treatment for this condition was therefore at once instituted. It consisted in the use of ice, the frequent application to the affected surfaces of a twenty-five per cent solution of ichthyol, as suggested by Dr. J. H. Abraham, of New York, and the administration of

calomel. The inflammation in the throat was very severe and threatened at any moment to become dangerous, in view of the involvement of the larynx and the possible increase of the edema to the point of causing sudden and urgent dyspnea. Every preparation was made for this emergency and Dr. Armstrong remained with the patient all night. March 23, breathing was easier and the throat seemed less swollen. Patient complained that the mucous membrane of the nose felt sore and, as he described it, stiff. Ichthyol applications to the throat continued. On March 24, the external surface of the nose, both cheeks, both eyes and the right ear became red, swollen, hot, painful and tender. Breathing was easier and the throat had improved. On March 25, the inflamed area extended well upon the forehead. Urine, acid, specific gravity 1015; distinct cloud of albumin, no sugar, occasional hyaline and granular casts. March 27, the entire scalp and back of neck were involved. The throat, nose and face were clearing. March 29, the face was desquamating and the scalp and the back of the neck clearing. March 30, no local symptoms present. From this time on recovery was uneventful. On April 17, the patient developed a right-sided tonsillitis threatening quinsy. The attack was severe, but at the end of nine days it had entirely resolved without formation of abscess. Little fever accompanied it and comparatively little pain.

Two cases of erysipelas of the larynx and pharynx observed by the writer a number of years ago, are highly illustrative of the serious results which may attend erysipelas of the upper air passages. A man of 29, previously healthy, was taken with chills, general muscular soreness and pain in the bones, a slight soreness of the throat and dysphagia. The tonsils were congested and slightly enlarged. On the day following, the patient grew worse, complained of dryness of the nasal passages and inability to breathe through the nose. There was moderate elevation of temperature. Two days later he was transferred to the hospital, all of the above symptoms being exaggerated. On admission, his temperature was 102°, pulse 96, respiration 27; tongue and teeth covered with sordes; tonsils and pharynx deeply congested. At this time also an herpetic eruption appeared on the face below the outer side of the angle of the mouth. Five days after the onset of the attack an erysipelatous redness, attended with swelling, appeared upon the upper lip adjoining the alae of the nose and fading off upon the cheeks. There was also severe pain in the back of the head and neck. There was little malaise. Temperature, however, was 104°, pulse 96, respiration 24. Within two days the swelling and redness

had extended to the margin of the hair and had invaded the neck; the face was covered with blisters. The pulse was running and intermittent at 80 and the tongue black and dry. There was still severe pain in the back of the neck and the erysipelas was not extending. Nine days after the onset, the patient fell into a semi-comatose condition from which it was impossible to arouse him. Two days later the semi-consciousness had continued and the patient became very restless and delirious. Meanwhile the facial swelling had subsided and desquamation had begun. The tongue was still black and thickly coated. Pulse and temperature normal.

Following this the patient again became delirious, the delirium assuming an active and hilarious character, while the local condition greatly improved. He was discharged apparently cured, after four weeks of illness. Four days after discharge, however, he began to show signs of mental aberration. He had delusions of a religious character, was treacherous and quarrelsome. He became violently insane, was transferred to the asylum at Ward's Island and when last heard of, was still there.

A second case of the writer's was that of a woman of 70, large, stout and rheumatic. She was attacked with what at first seemed an acute laryngitis. The disease, however, spread rapidly in both directions, involving both of the lungs and the pharynx, and producing in the former a distinct and widespread broncho-pneumonia and in the pharynx an intense congestion. The mucous membrane here was also edematous and of a dark, purplish color. So peculiar was its appearance and so threatening the extent of the edema that a laryngoscopic examination was made to ascertain the probable necessity for tracheotomy. Although in a general state of tumefaction and of the same dark color as the pharynx, there was an ample rima glottidis but marked hoarseness of the voice. Constitutional symptoms were slight considering the nature and severity of the attack. By degrees the inflammation extended from the pharynx to the lips whence apparently having received a fresh impetus it spread over the face. Meanwhile the co-existence of diarrhea, mild delirium and continued high temperature rendered the general condition grave. This period marked the height of the attack. The lungs were first to improve and the disappearance of the pneumonia was followed by a subsidence of the laryngeal and pharyngeal inflammation and a marked improvement in general. As desquamation occurred on the face and neck, the erysipelas extended by slow degrees over the whole body, the march being slow, the general symptoms mild and no great extent of surface being affected at any

one time. At the end of several weeks this process was completed by involvement and subsequent desquamation of the legs and feet. The patient recovered.

Case No. 1 above related would probably constitute a severe exhibition of class one of Cornil. As far as was known, the patient had not been exposed to erysipelalous infection. The suddenness of the onset in this case is a feature of particular interest. In other cases seen by the writer this has been more gradual. Another feature of the case is its freedom from all complications and the rapidity with which the symptoms subsided in spite of the marked severity of the attack. From the threatening appearance of the symptoms when first seen it is fair to believe that the treatment instituted had a marked influence in effecting relief. The occurrence of the severe tonsillitis eighteen days after recovery in a patient not accustomed to such attacks suggests a persistence of infection.

In case No. 2, quoted from my former article, the features which especially distinguished it are, first, the occurrence of the disease idiopathically in a patient who as far as could be learned, had not been exposed to any erysipelalous infection. Secondly, a distinct limitation of the disease to the tonsils for a period of three days. Third, the marked cerebral disturbance and subsequent insanity.

The most important incident was, of course, the effect of the disease upon the brain. No history of any previous sign of mental aberration was obtainable. The insanity therefore bore such a distinct relation to the attack that the one seemed intimately associated with the other. It is by no means unusual for facial erysipelas of the ordinary type to be complicated with delirium and coma and even with the more serious cerebral symptoms indicating meningitis. It is not surprising, therefore, to find it developed in such a case as the one under consideration. Whatever other theory may be advanced to explain the extension of the disease to the interior of the cranium, it is interesting to note the possibility of its direct incursion from the deeper layers of the olfactory region through the cribriform plate of the ethmoid bone to the meninges, or, as is also possible, from the surface of the face in the vicinity of the nose, forehead and eyelids through the anastomoses of the angular branch of the facial and other superficial vessels with the ophthalmic vein. It has been long ago pointed out by Mr. Spencer Watson, by Mr. Frank Ogston and others, that such extension from the nasal cavities is possible and that in cases where there is intracranial involvement the symptoms may come on very insidiously, the nasal disease often being quite overlooked. In such cases the

appearance of meningitis seems inexplicable or is attributed to some other cause. While it is improbable that in ordinary conditions of chronic inflammation the disease should thus extend itself, still it is not difficult to believe that a violent phlegmonous lesion of the deeper structures of the olfactory region might communicate itself to the neighboring highly vascular structures of the brain cavity. Still more reasonable is it to suppose that erysipelas involving the integument of the nose, forehead and eyelid should be conveyed to the brain cavity by the way of the ophthalmic vein. The influence of inflammatory conditions of the middle-ear and of the frontal sinus in exciting cerebral complications is well attested.

Case No. 3 is more after the usual course of the disease. The patient was old, feeble and lithiatic. She was housed in a crowded, ill-ventilated hospital ward in which, although there may not actually have been another case at the time, erysipelas was never long absent. That the original seat of the disease was the larynx, was plain, while its extension to the lungs on the one hand and to the pharynx and the general surface on the other, in spite of which extension the patient recovered, renders the case one of rare and peculiar interest.

In an article published in the *Rivista clinica e terapeutica* as far back as 1885, by Professor Ferdinand Massei, of Naples, the writer endeavored to prove from a study of thirteen cases that the so-called primary edema of the larynx, or phlegmonous laryngitis, corresponds clinically to the localization of erysipelas in the larynx. Several years ago in an address delivered in Brooklyn, Dr. Felix Semon classified all of the phlegmonous conditions of the throat, including quinsy, abscess at the base of the tongue and of the epiglottis, and angina Ludovici as one and the same affection. The bacteriological features of all of these conditions, including the so-called erysipelas of the throat are markedly similar and to that extent the different manifestations of infection may be regarded as identical. Clinically, however, the differences are very great, especially when surgical intervention becomes necessary for the evacuation of abscesses which may have formed. The treatment called for, both general and local, may be more or less the same in the different manifestations of the disease.

The somewhat wide range of possibility as to the location of abscess renders the identification of the focus of the infection in some cases extremely difficult and may call for a high degree of anatomical and surgical skill in dealing with them.

1 East Thirty-third Street.

CLINICAL STUDIES OF FIVE CASES OF SUPPURATIVE LABYRINTHITIS.*

BY PHILIP D. KERRISON, M. D., NEW YORK.

The various tests of vestibular irritability have been the subject of so many papers during the past few years that universal appreciation of the facts and theories upon which they depend may be assumed. The surgical significance of loss of caloric reaction is in some cases obvious. In others it presents problems of considerable difficulty. In bringing the subject before you again, my purpose is to recite briefly a few cases from my own experience in which caloric irritability was absent.

Case 1. DIFFUSE SUPPURATIVE LABYRINTHITIS COMPLICATING MEASLES. This case is reported somewhat in detail as presenting in regular sequence all the classical symptoms of the disease from the onset to the final recovery following a labyrinthine operation. Miss A. W., trained nurse, 21 years of age, was admitted to the Willard Parker Hospital in December, 1908, suffering from a severe type of hemorrhagic measles. The ears, examined on admission, were reported to have been normal.

On or about January 5, 1909, she developed acute purulent otitis media of right ear with some mastoid tenderness. Myringotomy by the resident physician. Two days later, when I first saw her, a mastoid operation was clearly indicated. Removal of the cortex revealed pus in the antrum and extensive inflammatory changes throughout the mastoid cells.

Five days after the operation, when still very ill from the systemic infection, she developed the following additional symptoms, viz.: Marked rotary nystagmus to the left, which was most pronounced when the eyes were voluntarily turned to the left. She complained much of subjective vertigo. She was nauseated and vomited several times during the day. These symptoms underwent gradual but progressive diminution. During the dressing of the wound as she lay with the left ear buried in the pillow, the deafness of the right ear was very noticeable. During the month following the operation, the patient gained strength very slowly and the wound showed hardly any signs of repair. The bone remained comparatively bare of granulations, and such granulations as did

*Read before the Eastern Section of the American Laryngological, Rhinological and Otological Society, Boston, Mass., February 4, 1911.

form were of the type characteristic of bone disease rather than of repair. To correct this condition, a secondary operation was performed on February 17. This operation, which was essentially a curettage of the original wound, showed extension of bone necrosis in various directions. Following this the wound took on a healthy appearance except at the aditus where pus continued to collect. During the month following, the patient rapidly gained weight and strength, and was soon the picture of health. She now experienced absolutely no vertigo, and there was no disturbance of equilibrium. There was no nystagmus.

On March 22, the condition of the right ear was as follows: A large perforation was seen in the upper posterior quadrant of the membrana tensa. Into the mastoid wound pus still escaped through the unclosed aditus. Functional examination showed complete deafness of right ear. Caloric reaction absolutely negative. On March 24, a radical labyrinthine operation was performed. No trace of malleus, incus or stapes was found. The oval window was therefore open. A fistula leading into the horizontal semi-circular canal was present.

The labyrinthine operation included opening of the vestibule, the lower wall of the horizontal canal being used as the surgical guide to its position, removal of the promontory and careful curettage of the cochlear space thus laid bare. The patient recovered with a dry tympano-labyrinthine cavity, but, of course, with absolute unilateral deafness.

Case 2. DIFFUSE SUPPURATIVE LABYRINTHITIS, LATENT STAGE, WITH BEGINNING CEREBELLAR INVOLVEMENT. S. M., a girl of 14 years, had been under my care for chronic middle-ear suppuration. In July, 1908, during my absence in Europe, a radical operation had been performed by a competent surgeon which, however, had not resulted in a cure. She was discharged from the hospital, but kept under treatment in the dispensary. Her condition later becoming unsatisfactory, she was re-admitted to the Manhattan Eye and Ear Hospital, on November 26, 1908. From this time she was continuously a hospital patient, and for some weeks before she again came under my care was bed-ridden.

On February 24, 1909, when I had an opportunity of examining her again, her condition was about as follows: While not exactly emaciated, she had very noticeably lost flesh. She was unable to stand without support, this inability being apparently due to muscular paresis rather than to any characteristic ataxia. She fell not forward, backward nor laterally, but as by muscular collapse, her

legs simply bending beneath her. She complained somewhat of vertigo. There was no characteristic vestibular nystagmus. The effort with eyes closed to bring the tip of the index finger quickly to the tip of the nose showed very marked inco-ordination ataxia, and in this there was no noticeable difference between the two hands. At this time she complained chiefly of very severe headache. She had vomited frequently during the past few days. Her condition was evidently grave, and the advisability of an exploratory operation upon the brain was under consideration.

At this point, it was decided to test her caloric reactions. Prolonged irrigation of the right ear alternately with hot and cold water produced absolutely no reaction. Irrigation of the left ear quickly induced a strong normal reaction. The right ear, tested with the aid of the Bárány noise apparatus, was absolutely deaf. On the deafness and absence of caloric reaction, it was decided to investigate the condition of the right labyrinth.

Operation: On opening the old mastoid wound, the sigmoid sinus was found extensively exposed. Behind this, bone was removed over a considerable area of cerebellar dura; and here the dura was eroded, or at least covered with granulations, over a circular area as large as a nickel. On exposing the inner tympanic wall no trace of the stapes could be found, and granulations were seen protruding from the eroded oval window.

The labyrinthine operation included opening of the horizontal semi-circular canal and vestibule, removal of the promontory and curettage of the cochlear space thus exposed. This completed the operation. Neither the anterior nor the posterior vertical canal was opened. Sterile gauze was placed against the cerebellar dura, and the tympano-labyrinthine cavity was packed with iodoform gauze. The patient made a slow but satisfactory recovery.

In this case the symptoms, though indefinite, suggested a brain lesion rather than labyrinthine disease. The negative "caloric," in directing attention to the labyrinth, deterred me from an unnecessary exploratory operation upon the brain, and probably saved the patient's life.

As far back as 1907, the Vienna school had already formulated the dogma that in chronic purulent otitis media accompanied by signs of suppurative labyrinthitis, acute or latent, the labyrinth should be opened and drained, or no operation should be performed. The two following cases bear upon this creed.

Case 3. LATENT DIFFUSE SUPPURATIVE LABYRINTHITIS OF LONG STANDING, ULTIMATELY LEADING TO CEREBELLAR ABSCESS. J. F.,

laborer, 60 years of age. History and physical signs of chronic purulent otitis media of right ear, dating from childhood. Patient complained of pain in region of right mastoid, which also was somewhat sensitive to pressure. Hearing tests showed apparently complete deafness of right ear. Caloric test absolutely negative. There were no symptoms of vestibular irritation, and the patient denied ever having experienced marked dizziness in his life. From this negative history I argued that the patient at some time in the past had suffered a suppurative invasion of the labyrinth, the symptoms of which he had long since forgotten; and that the labyrinthine lesion had very possibly undergone resolution, leaving its results, however, in the deafness and loss of vestibular irritability. I decided, therefore, to do a radical operation, and to open the labyrinth only if physical evidences of labyrinthine disease were found.

Operation, April 30, 1909. During the course of the operation, the regions of the oval window, the promontory and the horizontal canal were carefully scrutinized, but no evidences of a labyrinthine fistula were found. The operation was completed by the usual steps of the radical operation. The patient was dismissed from the hospital on June 7, but the ear still discharged, and he complained of frequent headache.

Late in September, 1909, during my absence from the city, the patient was re-admitted to the hospital complaining of severe headache which he associated with his aural lesion. A secondary operation by a hospital colleague did not relieve the patient, who died suddenly on September 30. Autopsy revealed a cerebellar abscess of the size of a hazel-nut and surrounding purulent meningitis. The labyrinth was filled with pus.

I believe that this patient's death was directly due to my error of judgment in not having operated upon the labyrinth at the time of the original radical operation.

Case 4. L. M., Italian, 36 years of age, had suffered from a chronic suppurative lesion of his left ear since early childhood. Twelve years ago, he experienced a severe attack, the symptoms of which he remembers as nausea, frequent vomiting, and severe dizziness, and which confined him to bed about ten days. Since this attack, he has been deaf in left ear. Three years ago the patient contracted syphilis, for which he is still under treatment. Functional tests showed absolute deafness of left ear, normal in right. In this case it was decided to combine surgical opening of the labyrinth with the "radical" operation.

Operation, December 6, 1909. The preliminary radical operation was performed upon a sclerotic bone of unusual density. The more or less soft cellular bone usually surrounding the bony capsule of the labyrinth was replaced by hard, dense bone, rendering the labyrinthine operation more difficult. Opening of the horizontal semicircular revealed a canal of abnormally small caliber. The excavation inward and downward through or behind this canal toward the vestibule was made difficult by the unusual density of the bone. The vestibule, when opened, was found to be a minute cavity containing thick pus, and apparently not more than two mm. in any diameter. In order to ensure drainage, the promontory was removed.

Apparently in this case the suppurative lesion had been followed by a process of osteo-sclerosis, as a result of which the labyrinthine spaces had been encroached upon, and considerably reduced in size. The patient is still under treatment for a slight discharge, which comes, apparently, from the Eustachian tube.

Case 5. A woman, 35 years of age, had suffered from chronic left middle-ear suppuration of many years' duration. The present condition is as follows: The left membrana tensa and Shrapnel's membrane are practically destroyed. The inner margin of the roof and posterior wall of the bony meatus is to a very considerable extent eroded, providing a wide opening into the vault and aditus. The inner wall of the tympanum is covered with epidermis. Hearing tests, with the sound ear closed, by means of a Bárány instrument show useful hearing power in the left ear. Caloric reaction of left ear,—absent two months ago, possibly by reason of granulations in vault and aditus which have disappeared under treatment,—is now normal, being induced well within fifty seconds. Fistula test: Compression induces marked horizontal nystagmus toward diseased (left) ear; suction produces similar but less active nystagmus toward right ear.

In this case, we have evidently to do with a suppurative lesion which has produced a defect (fistula) in the bony capsule of the labyrinth, probably communicating with the horizontal canal, but which has not resulted in infection of the membranous labyrinth.

Case 6. This is an unusual example of the results of neglect. J. H. is a boy of 4 years. He contracted measles during his first year, which was followed by a constant discharge from the left ear. When about three years old, he developed facial paralysis of left side, soon becoming complete, but later making a slow, partial recovery. When first seen at the Manhattan Eye and Ear Hospital,

the condition was as follows: Typical subperiosteal abscess behind the left ear; profuse offensive otorrhea; a small mass of granulations (polyp) had its origin from about the middle of the denuded posterior wall of the bony meatus.

Operation: Exposure of the left mastoid revealed two cortical perforations, one near the tip, the other above and behind the spine of Henle. On attempting to use a curette, a large sequestrum, including the postero-superior wall of the bony meatus, detached itself and was removed. The radical operation was therefore predecided for me. The facial canal was open throughout the horizontal portion. A fistula was present in the anterior part of the promontory. A necrotic tract extended from the antrum inward behind the semi-circular canal system. This I curetted as well as I could without entering the labyrinth from behind. Owing to the patient's youth, and not having tested the labyrinthine function, I was averse to operating upon the labyrinth, but kept the posterior wound open in order to have the wound cavity in better view. Following this operation, the condition of the wound at each dressing was so foul that I was literally forced two weeks later to perform the usual labyrinthine operation. The facial paralysis is again complete, but the patient is otherwise making satisfactory progress toward recovery.

This short series of cases suggests certain points for discussion, e. g., the stage of the disease most favorable for surgical intervention; the dangers of the labyrinth operation itself; the merits of the Vienna theorem, that in suppurative labyrinthitis we should operate upon the labyrinth or not at all.

As regards the most favorable time for the labyrinthine operation, I am firmly convinced that the latent stage of the disease is the period in which the labyrinth can be operated upon with least risk. Of the operative cases which have come within the range of my personal knowledge, nearly all the deaths have occurred in cases operated upon during the acute stage. There are admittedly certain cases in which the onset is followed by such pronounced signs of meningeal irritation that one is obliged by the urgency of the symptoms to operate. Such cases, I believe, are comparatively rare. One must bear in mind that vomiting, headache and elevation of temperature are distinctly characteristic of vestibular irritation, and are not necessarily indicative of meningeal disease. When these symptoms are not excessive or too prolonged, surgical intervention should be delayed. In typical cases the clinical picture will show marked improvement within a few days or a week. In the

first case cited, had I operated upon the labyrinth during the acute stage,—i. e., while symptoms of vestibular irritation were still present—I very much doubt whether the patient would have recovered.

As to the dangers of the operation itself, I do not believe that it is a particularly dangerous procedure if performed during the latent stage, and if the surgeon has formed a rational and conservative view of the mechanical results to be attained. What we wish to accomplish is in most cases free drainage of the labyrinthine spaces, and this is accomplished when the vestibule is freely opened and a counter-opening is made by removal of the promontory below. It matters not by which route the vestibule is reached, provided it be freely opened, and no important structures injured in the approach thereto. Obviously a fistulous tract leading into one of the semi-circular canals should be followed up as the logical guide to the original pathway of infection. Further than this, the separate opening of each semi-circular canal is not called for and adds nothing to the patient's chances of recovery. These little canals open only into the vestibule, and when the latter is opened and drained, all that can be accomplished, so far as the canals are concerned, is attained. When the promontory has been removed, granulations within the cochlea should be removed by means of a curette. To attempt more in this particular field reduces, rather than adds to, the chances of recovery in the great majority of cases.

As to the question of operating in cases of chronic middle-ear suppuration with evidences of past suppurative labyrinthitis:—is it safe in such a case to perform a radical operation without at the same time opening and draining the labyrinth? Personally I believe that it is not. While in Case 4 of this series, the labyrinthine condition exposed by the operation hardly seems to have called for so extensive a procedure; in Case 3, the symptoms were not more urgent, and in this instance failure to open the labyrinth cost the patient his life.

With regard to Case 5, in which a fistula leads to a functioning labyrinth, I am still somewhat in doubt as to the best plan of treatment in such cases. Would a radical operation ensure the patient's safety? Apparently there are two sides to this question. If by careful surgery epidermization could be obtained after thorough removal of all diseased bone, including that lining the fistulous tract, the element of danger would seem to have been removed. On the other hand, if the operation should fall short of complete removal of the fistulous tract, epidermization might add greatly to the dangers of labyrinthine infection. A further possibility in such

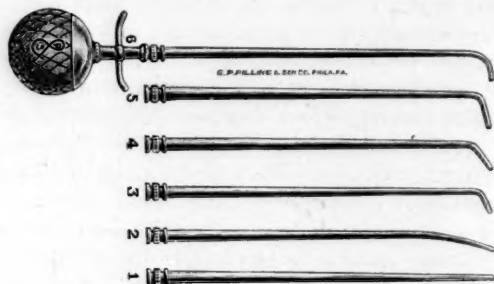
a case lies in the chance—probably rather remote—that any operation might excite acute inflammatory changes along the tract of the fistula leading rapidly to suppurative labyrinthitis. In view of the above considerations and of the fact that the tympanic condition has greatly improved under local treatment, it has seemed to me that a radical operation would be unwise in this case.

58 West Fifty-Sixth Street.

A SET OF ANTRAL CANNULAE.

BY JOHN DUNN, M. D., RICHMOND, VA.

None of the instruments best adapted for specific work in the upper air-passages accomplish their object so unsatisfactorily and with so much difficulty as the antral cannulae with which I am acquainted. The difficulties met with in the use of those on the market caused me to have constructed by Messrs. Geo. P. Pilling, Son and Co., of Philadelphia, the set here illustrated. The accompanying wood-cuts make necessary very little in the way of verbal description. The set consists of six tubes. Three of them, num-



bers 3, 4 and 5, are for use in the frontal sinuses; two, numbers 1 and 2, are for use in the maxillary and sphenoidal sinuses and for flushing the region of the middle turbinates; number 6 has been added and is useful in certain abnormal conditions which readily suggest themselves. The cannulae are six inches long and have a screw attachment to a rubber bulb, of a size small enough to allow easy manipulation while the tubes are being inserted. The curves of the frontal cannulae are adapted from that of the frontal duct curette of Dr. T. C. Worthington, of Baltimore.

314 East Franklin Street.

A NON-CAUSTIC CRESOL (CRESATIN) IN DISEASES OF THE NOSE, THROAT AND EAR.

BY M. D. LEDERMAN, M. D., NEW YORK CITY.

For a year or more, I have been using this new cresol compound as a local application in various pathological conditions of the upper air-passages and ear, whenever an antiseptic was indicated, and have been favorably impressed with its therapeutic activity. It is offered as a valuable substitute for carbolic acid and the cresols, possessing their well-known bactericidal and analgesic properties, but being devoid of irritating and escharotic action.

Cresatin is the acetic-acid-ester of meta-cresol, and represents about seventy-two per cent of meta-cresol, which is the least toxic of the cresols and less toxic than carbolic acid. It retains the characteristic antiseptic and analgesic effects of meta-cresol, without the above-mentioned objectionable features. Being less of a coagulant of albumen, its penetrating powers should be more decided than carbolic acid.

Cresatin is soluble in animal or vegetable oils or fats, also in alcohol, but practically insoluble in water. It is stable, does not discolor or undergo any other change on standing. Being a definite chemical compound, it is always uniform, distilling without decomposition at 214° - 215° C.

In a number of cases of furunculosis of the external auditory canal, this preparation was applied in full strength on cotton tampons. The canal was previously cleansed with alcohol, and the saturated tampons were then placed firmly in position over the infected area. This treatment was repeated every two or three hours by the patient. A sensation of warmth was at times noticed, which was soon followed by a feeling of relief from the previously existing pain. This analgesic action was observed in a number of instances. In some of the cases, where suppuration had not appeared, pus was seen on the tampons after a few applications. In other patients the tumefaction gradually subsided without visible evidence of pus, and with no recurrence of the infection.

Pleasant results were obtained in eczema of the external canal, especially where the symptom of itching was very annoying. The parts were first dried and cleansed of epithelial debris, and cresatin was painted over the affected areas in pure form. In some pa-

tients, prompt relief was experienced, but in the more chronic variety of the affection a few applications were required before the desired result was noted.

In chronic purulent otitis media, after cleansing the canal and middle-ear, the preparation was used rather freely, through the perforated membrane. At times, a tingling sensation was noticed, but this soon subsided and no discomfort followed. After a few treatments in this manner, the purulent discharge lessened and gradually ceased. In a case of cholesteatoma of the middle-ear and mastoid, where nature had performed a successful radical operation, accumulations of ceruminous and epithelial debris would at times cause irritation of the neighboring skin. Two or three applications of cresatin, after removal of the foreign material, would end the local disturbance.

On account of its antiseptic and penetrating action, I have employed cresatin in a few cases of atrophic rhino-laryngitis. The parts were first thoroughly cleansed of dried secretion, which is a necessary procedure in the proper treatment of this unpleasant and stubborn disease. The compound was then applied with considerable friction, in full strength by means of a cotton applicator, to all accessible areas. Post-nasal paintings were also given. The mucous membrane responded promptly to the stimulation, and the patient remarked that the parts felt moist and comfortable for some hours after the treatment. Most of these cases are clinic patients whose attendance was irregular; so no definite conclusions can be reached from them. In two private individuals who received more careful attention and who used also a twenty-five per cent cresatin in olive oil solution at home, decided improvement was noticed.

Home treatment in this obstinate and unfortunate affection must be a necessary adjunct. In the patient's hands a forcible atomizer* will probably give better results, as the medication will reach a greater area than by simple application.

Cresatin has been used in acute follicular tonsillitis with considerable success. It has also been found that the duration of the affection is shortened by direct application in pure form, thoroughly rubbed into the follicles. The analgesic and antiseptic effect in these cases makes it of decided value.

It should be of considerable service in painful lesions about the lips and mouth,—i. e., herpes facialis, fissured lips, aphthous stom-

*It is best to use an atomizer all parts of which coming in contact with the preparation are made of glass.

atitis, and in dental manifestations. It has been used with prompt effect in an abscess of the gum, after the pus was drained. In twenty-four hours no further discomfort was noticed. The cresatin was applied between the tooth and the gum.

In cases of folliculitis of the nasal vestibule, a few treatments with cresatin gave the desired relief.

Before ending these desultory observations, it may be of interest to mention the pleasant effect of this new analgesic antiseptic in a case of advanced tubercular ulceration of the epiglottis in a male 45 years old. Pulmonary disease had existed for over three years, and the local involvement had been under treatment by a colleague for some time. Lactic acid had been employed, but when I saw the patient for the first time, the extensive invasion of the epiglottis prompted me to test the merits of cresatin. The free edge of the epiglottis presented the typical moth-eaten ulceration, with some loss of tissue in the median line. The organ was considerably infiltrated, and the contiguous tissue over the lingual surface was very edematous. Dysphagia and paroxysms of cough were the symptoms chiefly mentioned. The man's general condition was good, appetite fair, and the painful area in swallowing was principally localized to the right side of the throat. A probe could be passed between the soft infiltrated tissues on the lingual surface of the epiglottis and the cartilage on the right side. After cleansing the parts, a ten per cent solution of cocain was applied at the patient's request, owing to previous discomfort under pure lactic acid treatments. Three paintings of cresatin were given at the first sitting, the liquid being carried under the raised tissue and thoroughly rubbed into the ulcerated areas. No unpleasantness was experienced from the rather heroic manipulations. In three days the patient returned for further treatment and stated that the application had given him considerable comfort and that deglutition was much easier. At the second visit no cocain solution was employed before applying the antiseptic and, except for a mild stinging sensation which soon passed away no annoyance was felt. As a result of these treatments, the infiltration was noticeably lessened, with a cleaner and healthier appearance of the ulcerations. A period of ten days elapsed before the patient returned to the clinic due to a catarrhal attack, and the lesions had again resumed their former state. Cresatin treatments were continued in the same manner as before, and beneficial results were again observed, the patient stating that if his throat "looked as well as it felt, it must have improved quite some." To further the local action of the

preparation, inhalations were carried on at home. Ten drops to a pint of steaming water for a period of fifteen minutes, twice daily.

While my experience in the above case is not cited as a criterion of the value of this new compound in this serious and distressing affection, nevertheless I have gained the impression that it is in this class of local infections and painful ulcerative lesions that a promising field for its analgesic and antiseptic activity is offered.

Cresatin alone or combined with the essential oils of eucalyptol, pine needle, or peppermint, with which it is readily mixable, may prove very serviceable in the treatment of infectious diseases of the upper air-passages. It may be used with an atomizer, vaporizer, or by steam inhalations.

I take this opportunity of thanking Dr. N. Sulzberger, the originator of this preparation, for his kindness in acquainting me with its physical and chemical properties and for his reports of laboratory investigations.

58 East Seventy-Fifth Street.

Unusual Sequestrum From Suppurative Otitis Media. A. H.

ANDREWS. *Jour. of Ophthal. and Oto-Laryngol.*, Dec., 1910.

A farmer, 66 years of age, had chronic suppurative otitis media for thirty years, with pain and gradually increasing facial paralysis for the last four months.

A radical mastoid operation showed an irregular cavity, the size of a hickory-nut filled with granulations, the bony tegmen was necrosed to the size of a dime, a discharging sinus led into the posterior wall of the auditory canal near the drum and the outer wall of the aqueductus fallopian was eroded and exposed the nerve at the inner wall of the tympanum.

Three weeks later recurrence took place and a second operation was undertaken, two months after the first operation, when a sequestrum was removed comprising the greater part of the petrous portion of the temporal bone. The mass measured one and one-eighth inches long, eleven-sixteenth of an inch wide and seven-sixteenths of an inch thick. Twenty-four days later the patient died of meningitis.

STEIN.

A SPECULUM FOR THE DIRECT EXAMINATION AND TREATMENT OF THE NASO-PHARYNX AND EUSTACHIAN TUBES.*

BY SIDNEY YANKAUER, M. D., NEW YORK.

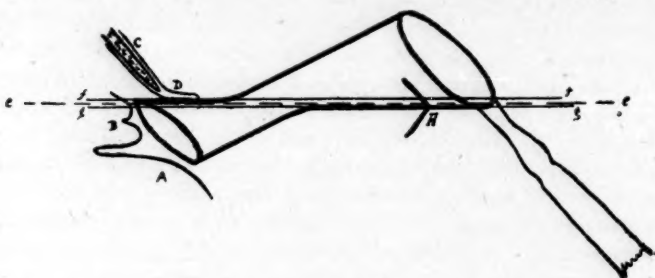
In order to determine the possibility of direct examination of the naso-pharynx and Eustachian tubes, I took a series of measurements upon the skull, the cadaver and the living subject during the past summer. I found that when the angle of the mouth was drawn back as far as possible, a line drawn from the angle of the mouth to the Eustachian eminence of the opposite side would pass behind the posterior border of the hard palate by a few millimeters. I accordingly began to experiment by using the short tubes of the bronchoscopic set with the Bruening electroscope, but found that in order to bring the parts into view in this way it was necessary to make such pressure upon the soft palate that ecchymosis of the organ was caused in most cases. I found that smaller tubes were less likely to cause such injury, and by carrying this idea to its mathematical limit, the conclusion is reached that a tube of infinitely small lumen would bring the parts into position with the least amount of pressure on the soft palate. By a peculiar mechanical construction I succeeded in so shaping a tube as to accomplish this purpose, and yet to retain a lumen sufficiently large to expose a large field of view and to permit of illuminating the field by means of a head-mirror, thereby avoiding the use of cumbersome electric illumination. This object was accomplished by making the anterior edge of that portion of the tube which enters the naso-pharynx come into line with the posterior edge of the portion which presses the angle of the mouth backwards. In the diagram (the head is thrown backwards as far as possible) A, represents the posterior pharyngeal wall, B, the Eustachian eminence, C, the hard palate, D, the soft palate, H, the angle of the mouth on the opposite side, E-E, the lumen of the infinitely small tube, F-F, its anterior wall, G-G, its posterior wall. The speculum is constructed as indicated by the heavy lines. In this way, the lever by which the soft palate is drawn forward has a thickness represented by the thickness of the metal only.

Although I have conceived this idea of the direct examination of the naso-pharynx independently, I have found recently that such

*Read before the Meeting of the Eastern Section of the American Laryngological, Rhinological and Otological Society, Boston, February 4, 1911.

direct examinations had already been made by Gyergyai, and published by him in the transactions of the German Otological Society last year. Gyergyai used straight tubes, which, as stated above, I have found objectionable on account of the injury to the soft palate which they cause, and which can be entirely avoided by using tubes such as here described. Besides, when using straight tubes, the patient must lie on his back with the head hanging low, and under these circumstances there is such a rapid accumulation of mucus over the field of observation, that, according to Gyergyai, the constant use of an auxiliary suction tube is absolutely necessary.

The speculum is introduced with the patient in the usual upright position. Cocainization of the naso-pharynx is necessary only in sensitive subjects, and then only for the first few times. The head is extended as far as possible, and turned toward the



side of the ear to be examined at an angle of 45° . The beak of the speculum is introduced behind the soft palate, the proximal part of the instrument placed in the angle of the mouth on the opposite side, and, using the cheek as a fulcrum, the soft palate is pressed forward until the parts come into view.

The posterior wall of the naso-pharynx and the fossa of Rosenmueller appear first. Adenoid masses can be seen and removed with the straight forceps. The interior of the fossa can be seen, probed, irrigated, packed. Adhesions can be cut with straight scissors, and applications made with an ordinary nasal applicator. By directing the beak a little further forward, the Eustachian eminence, and the orifice of the Eustachian tube, a vertical slit one-fourth inch long, can be seen. By means of a straight nasal applicator, solutions can be applied to the mouth of the tube or to its interior. A small tube about one-fourth inch in diameter can be introduced into the interior of the Eustachian tube, and its interior examined down to the isthmus.

The use of the direct method of examining the naso-pharynx is too recent to permit of speaking of clinical results. I will, however, mention that the fossa of Rosenmueller, especially, is the seat of interesting pathological changes. I hope to continue these studies at Dr. Emil Mayer's clinic at Mount Sinai Hospital, and to present the results of my clinical findings at the next annual meeting of this society.

616 Madison Avenue.

ELECTRIC LARYNGEAL MIRROR-HEATER.

BY JOS. D. HEITGER, M. D., BEDFORD, INDIANA.

The advent of the stereoptican electric lamp marked an advance in the use of electricity in the dark room, but deprived one of the use of the Argand burner for heating laryngeal mirrors. Soap, glycerine and other preparations have been used to prevent the condensation of moisture upon such mirrors but they have not proven satisfactory.

The electric heater shown in the illustration was devised to overcome all these difficulties, which it does very satisfactorily. It



can be easily attached, is clean, always sterile and withal, convenient. A moment's insertion of the mirror heats it to the desired temperature.

In the Section of Laryngology and Otology, at St. Louis, last June, I exhibited a modification of this heater.

I am indebted to V. Mueller & Co., of Chicago, for the careful way in which they have constructed this heater.

Heitger Building.

A NEW TONGUE-DEPRESSOR.

DANIEL W. LAYMAN, M. D., INDIANAPOLIS, INDIANA.

The tongue depressor here represented is devised especially for operative work under a general anesthetic, when the tongue is held by an assistant. The instrument conforms readily to the shape of the floor of the mouth, when the tongue is depressed, holding the tongue firmly downward and forward.

The handle is so constructed that it affords a firm, non-slipping grip. There is a groove on the inner side of the upper part of



handle, in which rests the index finger, and below the groove the handle is obliquely fluted. The handle is set at an obtuse angle from the rest of the instrument so that it is out of the way of the patient's chest.

The part of the mouth-piece that joins the handle is so shaped that it overrides the teeth easily; the drop or downward curve at the end, which joins the tip, is so placed that it permits a free forward or backward placement of the instrument. One size tongue-depressor serves for both adults and children.

The tip is nearly triangular in shape, and is serrated on the tongue side and curves down just enough to conform to the shape of the depressed tongue. The downward drop of the tip gives an advan-

tage of at least an inch or more over the ordinary right-angled tongue-depressor; thus the tongue is held in the desired position with less effort. It does not obstruct the view of the operative field, and is out of the way of other instruments.

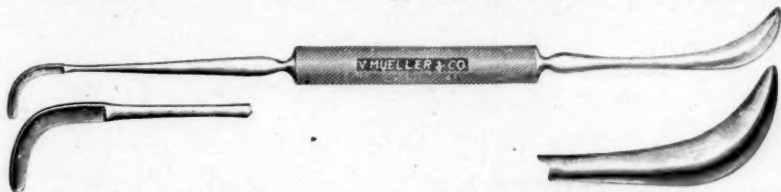
For the usual office work, if preferred, one can use a depressor without the serrations, as the rough part sometimes irritates the tongue. The instrument can be made with a broader tongue-piece if desired, for use in cases of large unruly tongues, that have a tendency to elevate on the sides when depressed in the center.

212 Newton Claypool Building.

TWO WELL-KNOWN TONSIL-DISSECTORS MOUNTED IN CONVENIENT FORM UPON A SINGLE HANDLE.*

BY C. M. HARRIS, M. D., JOHNSTOWN, PA.

Several years ago, after becoming disgusted with the operation of amputating diseased tonsils with the tonsillotome, I began to practice extirpation as a substitute, using a snare to complete the procedure. I tried several types of knives and dissectors; but finally came to depend upon a Tydings knife as a means of severing the adherent mucous membrane and supplemented this by a blunt Smith-



dissector to thoroughly loosen the tonsil to its base before applying the snare.

Changing instruments always meant some interference with the progress of the operation and it occurred to me that if the knife and blunt dissector were placed on a common handle, this inconvenience could be eliminated. V. Mueller & Co. made me such an instrument, which has been used with satisfaction, and should prove desirable to those who care to follow a similar technic.

604 Johnstown Trust Building.

*Presented to the Section on Eye, Ear, Nose and Throat Diseases of the Medical Society of the State of Pennsylvania, Pittsburg, October 6, 1910.

SPECIAL EDITORIAL DEPARTMENT

THE DEAF

**Their Education—Improvement of Conditions—
Responsibilities and Participation of the Profession**

EDITED BY

JOHN DUTTON WRIGHT, M. A.
DIRECTOR OF THE WRIGHT ORAL SCHOOL FOR THE DEAF
NEW YORK CITY

"The problems of deafness are deeper and more complex, if not more important, than those of blindness. Deafness is a much worse misfortune for it means the loss of the most vital stimulus—the sound of the voice, that brings language, sets thought astir, and keeps us in the intellectual company of man."

Helen Keller to Dr. James Kerr Love, Glasgow, April, 1910.

The aim of this department of **THE LARYNGOSCOPE** will be to bring to the notice of its readers from month to month, facts that may be helpful to physician and patient in dealing with the life-problems involved in deafness. Suggestions from readers will be gladly received and all questions answered to the best of our ability.

The largest school for the deaf in the United States, and one of the finest and best equipped, is the Pennsylvania Institution in Philadelphia. Its equipment is valued at \$1,000,000, and its annual expenses are more than \$171,000. During a period of more than twenty-five years, under the able management of its Director, Dr. A. L. E. Crouter, the school has gradually been changed from one in which only manual methods of instruction were employed, to one where now only oral methods are used, both in and out of the school-rooms. This result has been obtained in the only feasible way by which such a change can be accomplished, namely by establishing an oral department absolutely segregated from the manual department, and gradually increasing the size of the oral at the expense of the manual until all pupils are given purely oral training and under purely oral conditions. In the current report of this institution just issued, Dr. Crouter speaks as follows of the present situation in his school.

"In the Intellectual Department, instruction has, in the main, been conducted along the same lines as in previous years, the only noteworthy changes being the increased attention paid to lip-reading and the entire

absence of all forms of manual methods. These changes are believed to have proven helpful in the work. Oral methods alone are now pursued in the instruction of all our pupils, and they are found quite adequate to their best advancement. In saying this, we do not claim to be able to make orators or public speakers of our pupils, but we do claim to be able to give them a good general education, and, in doing so, to train their powers of speech and lip-reading to the extent of enabling them to communicate freely with their relatives and close friends, and to express their thoughts in fairly correct English on all topics of general interest. Except in a comparatively few cases more than this may not wisely be claimed for any method. Any method of instruction that will give the average deaf child a fair command of his native tongue, a fair



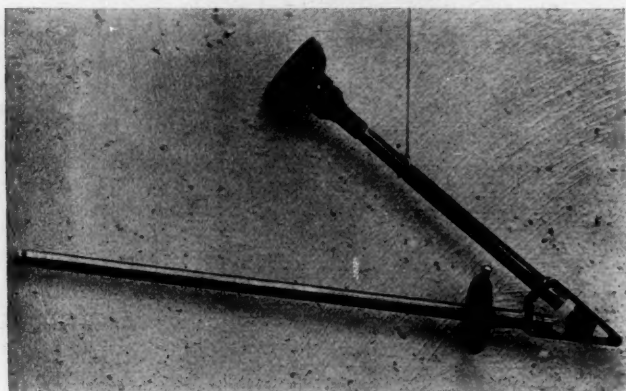
acquaintance with the subjects that constitute a fair English education, and the power to speak intelligibly and to read the speech of others is a good method, and any method that falls short of this, by whatever name known, is not a good method. We have dropped manual methods because we have found them unnecessary, and because we believe they interfere with the best progress of our pupils in the acquisition of speech and lip-reading and in all regular branches of study."

It is to be hoped that other states will in time follow the enlightened example of Pennsylvania and provide for their deaf children as satisfactory educational advantages.

The editor has devised for use in his voice-work with his pupils, a modification of Dr. Harold Hays' pharyngoscope, by which a person may see with wonderful clearness the operation of his own

vocal apparatus while producing sound. The accompanying cuts show the instrument in use by a pupil and also the telescopic portion which is the departure from Dr. Hays' instrument. This new part is made for use in the same sheath and interchangeably with the Hays telescope. Its construction involved the solution of some very difficult optical problems, and great praise is due to Mr. R. Wappler, of the Wappler Electric Manufacturing Co., for the wonderfully clear definition and illumination of the perfectly achromatic image that he has obtained. The manufacturer has called the instrument "Professor Wright's Auto-inspection Laryngoscope."

It is too early to know what practical results may be obtained by means of this new instrument in aiding the totally deaf to remedy their vocal defects. There are probably other fields than that



of the editor's in which such an instrument will prove valuable, now that it exists. The physician, the singing teacher, singers and actors may find it of value to be able easily to study their own vocal apparatus in action. In the Hays instrument the same objective can be used for examination of the larynx and the nasopharynx, but in this instrument, owing to the angles involved, a different lense is required for nasal work. The little lenses can be interchanged in a moment, so that the same instrument can be used for nasal and laryngeal work.

Only a working model has as yet been made and this is shown in the cut. Its greatest length is seven and three-quarters inches. Perhaps the best posture in which to use the instrument is the sitting posture, bending forward and downward toward the knees, as gravity draws the epiglottis forward and clears the field of view.

SOCIETY PROCEEDINGS.

CHICAGO LARYNGOLOGICAL AND OTOLOGICAL SOCIETY.

Regular Meeting Held November 22, 1910.

GEORGE E. SHAMBAUGH, M. D., CHAIRMAN.

Foreign Bodies in the Respiratory and Deglutitory Tracts. By STANTON A. FRIEDBERG, M. D.

Case 1. Female, 12 years of age, with an eyelet imbedded in a mass of granulation tissue springing from the left false cord. In order to remove it the tissue had to be cut on either side of the eyelet so that it could be loosened and removed with forceps.

Case 2. Boy, 7 years of age, with a stick-pin in the right main and lower secondary bronchus. Removed through upper bronchoscopy.

Case 3. Boy, 10 months of age, with a ring hooked over the left arytenoid and projecting downward into the esophagus. This was removed with the direct speculum and forceps.

Case 4. Boy, 2 years of age, with Belgian ten centime piece in the esophagus. A number of forcible attempts had been made to remove the coin before the child was brought to the hospital. The esophagoscope was passed but the coin could not be seen. At a later date Dr. Ingals also used the esophagoscope but could not see the coin. However, he succeeded in grasping it with an eight-inch forceps. This case terminated fatally.

Case 5. Girl, aged 5, had swallowed a marble about eleven mm. in diameter. This obstructed the esophagus so that the child was unable to take anything but a small amount of liquid nourishment. The marble was removed through the esophagoscope.

Case 6. Girl, one year of age, with penny in esophagus. Upon first attempt at removal the tube passed to the side of the penny. By the use of the direct speculum, holding the mouth of the esophagus open, the penny could be seen below and was easily removed.

DISCUSSION.

DR. E. FLETCHER INGALS stated that this operation is not entirely without danger. At the International Medical Congress at Budapest, Von Eichen, in analyzing three hundred and three cases of

bronchoscopy, found a mortality of thirteen and two-tenths per cent. These cases collected from the world's literature did not represent the actual mortality because many fatal cases are not reported. Jackson places the mortality at about three per cent but he omitted certain cases which, if included, would make the mortality nine per cent. The value of the operation is recognized, but it is important that every means to prevent its dangers should be found. The principal sources of danger are the anesthetic, broncho-pneumonia, emphysema, dilatation of the heart, traumatism and sepsis.

Anesthetics: Cocaine in small quantities properly guarded does no harm, but the use of larger quantities which may seem desirable to produce anesthesia in the larynx and the bronchi may be exceedingly dangerous, especially in children. Dr. Ingals used chloroform in a considerable number of cases, but now uses ether altogether. This anesthetic also is dangerous when continued for a long time, since it is more likely to cause broncho-pneumonia than is chloroform. Dr. Ingals has adopted the plan of giving a full dose of atropin four hours before operation and a second full dose of atropin with a medium dose of morphine one hour before operation, to prevent excessive secretions. Dyspnea adds much to the danger and when severe it is rarely safe to attempt upper bronchoscopy. In any case the operator should be ready to do rapid tracheotomy. In cases of marked dyspnea, tracheotomy should be performed first. Intubation may relieve post-operative dyspnea caused by irritation of the larynx.

Broncho-pneumonia may be due to either the ether or mechanical irritation. Exposure afterwards may also cause it. As a means of prevention, he urged that the operation should not be prolonged, that it should be as gentle as possible; that tubes which stretch the bronchi should not be used, and that the child be placed in a croup tent for forty-eight hours afterwards, keeping it very warm and moist. The temperature should be 85° F. He advised after bronchoscopy the administration of aqua ammonia acetalis, two drams every four hours for a child 6 years old.

He referred to a case that he had heard reported where the child died of a rupture of the bronchus, which was probably due to the use of a large bronchoscope. In another case, death occurred from hemorrhage. Traumatism may also occur from an instrument with a sharp edge, such as a forceps with teeth, or any instrument that might catch the mucous membrane. Formerly he used aspiration to

remove the mucous. He now relies on swabbing with sterile gauze in order not to injure the mucous membrane. In one operation, two cotton swabs came off in the lung. Since then he uses a small piece of gauze attached to a long string. The danger from sepsis he believes comes largely from introducing the bronchoscope into the esophagus before or during bronchoscopy.

Among things that had aided him much in his work were an old curved esophagus forceps, which is easily manipulated and which is often effective in removing foreign bodies and especially coins; also an eight-inch artery forceps when the object is in the esophagus above the sternal notch. He had found his open tube spatula with the handle set at an acute angle, about 40° , very helpful in introducing the bronchoscope, and a steel tube-director over which the bronchoscope might be passed through the glottis was often very valuable. He always began the operation prepared to use either the internal or reflected light, or both, and generally used both before the operation was over.

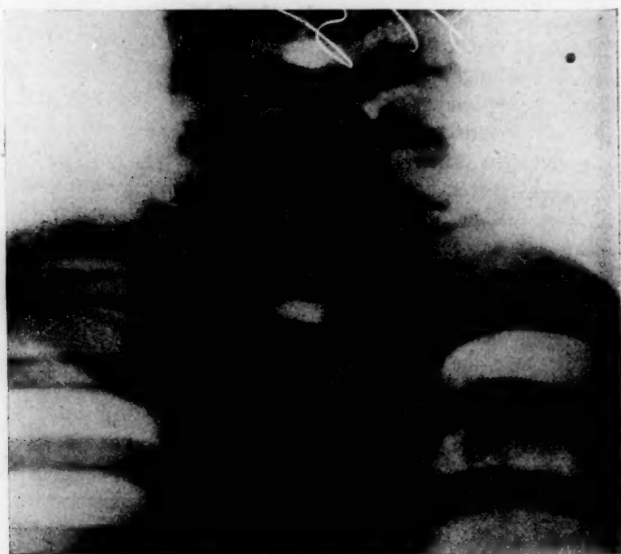
DR. W. E. CASSELBERRY emphasized the importance of a complete rehearsal just before operating on a case, in which every bit of apparatus is tested and all of the manipulations gone through on a manikin supported in the position of the patient. This rehearsal is valuable in testing the lights, which so often fail when they are introduced into the bottom of the tube. Such a rehearsal will shorten very much the time of the operation. Dr. Casselberry is now using a Kierstein light in addition to the distal light. The distal light illuminates the immediate field, but does not project the light ahead; this is accomplished with the Kierstein headlight. The rheostat and street current are used for the head light, a pocket battery for the distal lamp. To carry out this plan of illumination, he has had the Jackson tube made funnel-shaped at the top more like the Killian tube.

The pin-cutter referred to was devised by Dr. Casselberry to meet a necessity. It cuts the pin, at the same time preventing the two ends from flying asunder.

DR. J. C. BECK called attention to the fact that false shadows in the skiagram are caused by the bronchial tree and calcified bronchial glands. It is important to interpret the skiagram correctly. The only way this can be done is to make stereo-radiographs. This removes false shadows and avoids distorted shadows. He did not agree with Dr. Ingals that it was always easier to pass the bronchoscope into the esophagus than into the larynx. In one of his

cases the difficulty lay in not passing the tube into the larynx when he desired to enter the esophagus. He finally succeeded in doing this by not throwing the head of the patient back as far as is usually done.

He desired to place this case on record, the history of which is as follows: Boy, 5 years old, while playing with a quarter, placed it in his mouth and swallowed it. A few moments later the mother noticed that the boy had some difficulty and called the physician, who suspected that the coin had lodged in the throat, but on failing to find it by the ordinary examination, he sent the case to the Cook



County Hospital, where it came under the care of Dr. Beck. A radiogram was taken and located a shadow much larger than a quarter, about on a line with the sternal notch. This being late in the evening and the boy being able to swallow milk with little difficulty, it was decided to wait until the following day for operation. Just before operating, another radiogram was taken and this showed the shadow of the coin in the same position. The patient was placed under a general anesthetic (ether) and by the aid of the Bruening's esophagoscope an attempt was made to remove the coin. As said above, considerable difficulty was encountered in the

introduction of the esophagoscope, for there was a constant slipping of the end of the tube into the larynx. By not allowing the head to be retracted as much as is the custom, Dr. Beck was able to pass the tube into the esophagus but with the disappointment that at the point back of the sternal notch, where he had expected to find the coin, there was none. However, by passing the tube four to six inches further down, the quarter was encountered lying transversely or flat against the vertebral column. A pair of grasping forceps was passed through the tube, the coin grasped and the tube, forceps and coin all withdrawn without any difficulty. The boy made an uneventful recovery. A stereoscopic radiogram was not taken. This method would have proven conclusively the great advantage of locating foreign bodies by this method rather than single pictures, which are so deceptive in showing the size as well as the location in the bronchi, as well as in the esophagus.

DR. A. H. ANDREWS, speaking of the location of foreign bodies in the chest by means of skiagrams, suggested a method he has used in other parts of the body, that is, placing an opaque object in a known position. This will serve as a marker. He usually places one in front and one behind. In one case, he was searching for a bullet that was supposed to have been shot into the ear. A piece of metal was placed in each auditory canal. The skiagram showed these two pieces of metal, but no bullet.

Non-Suppurative Ethmoiditis. By GEO. P. MARQUIS, M. D.

(Published in full in the January, 1911, issue of THE LARYNGOSCOPE, page 12.)

DISCUSSION.

DR. CASSELBERRY stated that he was impressed with the fact that in his old records there were a great many diagnoses grouped under the heads of rhinitis, hypertrophic rhinitis, atrophic rhinitis, which at present would come under the head of some nasal accessory sinus disease. He has come to the conclusion that nearly everything in the nose to-day is sinus disease although not necessarily suppurative. He thinks this is but the logical thing to expect where there exists a series of cavities with small outlets frequently subject to infection. Why should the freely drained mucous membrane of the nose proper be blamed instead of these poorly drained accessory cavities?

One cannot dispute the existence of ethmoiditis without suppuration. These cases may terminate in suppuration. They are but the early stages and may continue indefinitely without suppuration.

These conditions are exceedingly common and very disquieting to the patient. Especially marked is the tumefaction of the middle turbinate body. He does not agree with Dr. Marquis that a large number of these cases can be relieved without resection of a part of the middle turbinate. He believes that the value of saving every bit of membrane in the nose is largely a fancy. In his experience much of the membrane destroyed in operations is regenerated. In addition to the resection of part of the middle turbinate, it is frequently necessary to resect a part of the septum.

DR. FRANK BRAWLEY said that the majority of these cases consulted an oculist instead of a rhinologist, and usually come with a pocket full of glasses after having had their eye muscles exercised, etc. The close relation between the internal recti muscles and the ethmoid leads to the involvement of these muscles. In the diagnosis the presence of edema on the outer wall of the middle meatus was of great importance. One should remove enough of the middle turbinate to get a view of the ethmoid cells. The great tendency to the development of edema of the membrane covering the ethmoid is probably due to poor circulation both in the blood and lymph. In the use of the vacuum pump to draw secretions from the sinuses he has been able to produce experimentally the type of headache of which these patients complain. In one case where there was severe frontal headache, removing the anterior third of the middle turbinal and opening the bulla gave relief for a year, when the pains returned and it was necessary to perform a thorough exenteration of the ethmoid before permanent results were obtained. There was no secretion in the ethmoid cells, but there was edematous mucous membrane simulating granulation tissue.

DR. A. H. ANDREWS mentioned the considerable progress being made in this work. There are non-purulent inflammations which are just as uncomfortable to the patients as an empyema. In a number of cases where he had tried to save the middle turbinal, he had removed this later only to find that it was decidedly diseased. He thinks it extremely difficult to press the middle turbinal against the septum sufficiently to learn much of the condition of the ethmoid. If the granulations or polyps are well developed these may be seen. Only recently by pressing the middle turbinal over he was able to discover polypi beneath it in a case that had gone the rounds of the oculists without getting relief. Removal of part of the turbinate and part of the ethmoid has made the patient per-

fectly comfortable. The pain experienced in this case was in and about the eyes when reading. The relation between rhinology and ophthalmology is very close. He believes that many of these cases are not due to infection at all, but are the result of the swelling of the membrane which occludes the apertures. The absorption of air in the cells then brings about congestion and exudation and the further changes described by Dr. Marquis.

DR. WM. L. BALLENGER said that he did not believe that there is a hard and fast distinction between the suppurative and non-suppurative forms of ethmoiditis. He believes that all cases are suppurative. He has seen a large number of patients during the last five years who had been previously examined by competent oculists, in whom a hyperplastic type of inflammation existed. In some, the suppuration was present without hyperplasia. It is impossible to get relief from the use of glasses. The cause of the trouble is in the ethmoid. He removes the entire ethmoid labyrinth because in its partial removal he has encountered difficulties. In these cases the mucous membrane would swell so as to occlude, and very often infection followed. This he has never seen occur after exenteration of the labyrinth. The safest operation, he believes, is the complete exenteration. He has had one death, but he believes the patient had a pre-existing meningitis, the nasal operation serving to incite the old trouble. The patient died in a few days. The danger in operating in the ethmoid region is in partial work, not in complete exenteration. In cases where the hyper-plastic changes are not marked, it may not be necessary to do a complete removal. Like Dr. Casselberry he rarely makes a diagnosis of rhinitis of any type, since these cases are always of accessory sinus origin.

DR. J. C. BECK pointed out that the histological picture showed a difference between the two types, the suppurative and the non-suppurative. The stroma of a polyp is fine in texture, the mixomatous tissue is clear. There are a few inflammatory cells. The epithelium in the non-suppurative type is well preserved, in the suppurative type it is multiplied and piled up. In the suppurative, the texture of the polyp is denser than in the non-suppurative type. When the ethmoid bone is examined it appears different in the non-suppurative than in the suppurative process; in the latter there is osteitis and necrosis, in the former there is thickening of the bone, but no inflammatory change. He believes the entire removal of the middle turbinal is indicated.

DR. GEO. E. SHAMBAUGH said that he could not agree with Dr. Ballenger that the chief danger in operations on the ethmoid labyrinth lay in the leaving of some of the cells. Meningitis occurs not from extension through the roof of the ethmoid labyrinth, but by way of the cribriform plate which lies to the mesial side of the ethmoid cells. Meningitis follows operation on the ethmoid either because the operator has disregarded the cribriform plate, which is much more delicate than the roof of the labyrinth, and has broken through this plate, or because infection extends along the sheaths of the olfactory nerves or along the blood-vessel and lymphatic communication between the olfactory region in the nose and the meninges. Every effort should therefore be made to avoid injuring that part of the meatus nasi communis which contains the distribution of the olfactory nerve. This is the upper part of the septum and the plate that forms the median wall of the ethmoid labyrinth. If it be possible, as it will be, in some cases, to force the middle turbinated body against the septum and leave it standing while the ethmoid cells are freely opened, the chief danger of the operation, that of injuring the cribriform plate or the part of the membrane containing the distribution of the olfactory nerves, will be avoided. In cases where the middle turbinate has to be removed, which is the more usual situation, this should be done with cutting and not tearing instruments. In the subsequent cleaning out of the ethmoid labyrinth the operator should leave the median plate standing.

DR. MARQUIS in closing stated that when the middle turbinate was involved in the disease process, it should always be removed. This was usually the case in the suppurative type. In the hyperplastic type of ethmoiditis without suppuration, where the ethmoid cells are filled with polypi and the middle turbinate not involved, infraction of this body against the septum and the cleaning out of the ethmoid cells is all that is called for. Some of the non-suppurative cases may really suppurate at times, but there are other types where suppuration never occurs. There may be discharge, but it is thin and watery.

Case of Thrombosis of the Cavernous Sinus with the Post-Mortem Findings. Reported by DR. WM. L. BALLENGER.

The diagnosis was based on the presence of the characteristic exophthalmos associated with the usual septic symptoms of thrombosis. Post-mortem revealed no focus of infection that could be

recognized as such in the nose. There was an ulcerated lower molar tooth found, which Dr. Ballenger held responsible for the thrombosis of the cavernous sinus.

DISCUSSION.

DR. GEO. E. SHAMBAUGH was unable to see any reason for attributing the thrombosis of the cavernous sinus to the presence of a decayed lower maxillary tooth. The direct extension of infection from the nasal mucous membrane by the way of blood-vessel and lymphatic communication is much more plausible. He referred to a case of primary thrombosis of the cavernous sinus which he had reported at the last meeting of this Society where the post-mortem examination failed to discover any primary focus of infection elsewhere and where the conclusion reached was that the infection had gained entrance to the cerebral cavity by means of blood-vessel and lymphatic communication between the nasal mucosa and the structures at the base of the brain.

DR. J. R. FLETCHER exhibited the forceps described at the previous meeting, used for removing bone in various head operations.

Regular Meeting, December 20, 1910.

GEO. E. SHAMBAUGH, CHAIRMAN.

Cysts of the Antrum of Highmore. By J. R. FLETCHER, M. D.

Abstracted in THE LARYNGSCOPE, March, 1911, p. 154.

DISCUSSION.

DR. O. T. FREER agreed with Dr. Fletcher that bulging of the buccal, temporal and orbital walls of the maxillary antrum did not occur as a result of empyema or catarrhal inflammation of its lining, but was an evidence of the presence of the bony cysts described by Dr. Fletcher. The nasal wall, however, Dr. Freer had found to be an exception in this respect and he even regarded its protrusion into the nasal cavity, in the thin portion of the wall in the middle meatus, as characteristic in many cases of empyema of the antrum. In one case, indeed, that of a girl aged 12, the bulging involved not only the middle meatus, but the entire nasal wall as well, causing it to press firmly against the septum, carrying over the lower turbinate with it, the whole condition simulating a bulging tumor, for which it was at first mistaken. The reason for this extreme bulging was a collection of inspissated pus, which lay wedged in firm clots in the antrum. In this case the entire nasal wall, with the lower

and middle turbinated bodies, was removed, throwing antrum an nasal cavity into one, the patient recovering completely.

DR. ANDREWS referred to a case of antrum disease he operated upon three years ago. In opening through the canine fossa he came upon a very shallow but apparently healthy antrum. Having found unmistakable intra-nasal evidence of antrum disease, he punctured the posterior wall and found another and larger cavity containing pus in abundance. There must have been two antral cavities, separated by a complete partition, although he did not notice any communication between the anterior cavity and the nose or the posterior cavity.

DR. BECK referred to the ease with which the diagnosis can be made by means of the radiogram. He finds that as a rule there exists a marked symmetry between the two antra and not the asymmetry referred to by Dr. Fletcher.

DR. FLETCHER in closing stated that he agrees with Dr. Freer that the wall of the middle meatus may be bulging into the nose as the result of fluid in the antrum. When this exists it is confined to the membranous portion. Whenever the bone gives way one should suspect bony cyst. In Dr. Andrews' case he believes that the cavity first entered was a dental cyst. Regarding the radiograph as a means of diagnosis, he does not consider this a necessary procedure; besides, it is rather expensive. The fact that he has seen four of these cysts in a period of four years leads him to believe that they are much more common than one would judge from the number of cases reported.

Actinomyces in Tonsillar Crypts. By L. C. GROSVENOR, M. D.

DR. GROSVENOR called attention to the fact that the ray fungus has its native parasitic habitat in the stalks of such grains, grasses and corn as cattle feed upon. In this manner the actinomyces gain entrance into the mouths of cattle, lodging in the crevices where they set up actinomycosis of the jaw, tongue, etc.

Macroscopically this fungus is found as a yellowish, hard, dense, fibrous nodule. Microscopically it presents a granular center with radiating, branched, thickly tangled mass of mycelial threads terminating in club-shaped radiating forms.

Jonathan Wright, in the *Am. Jour. Med. Sci.*, July 1904, reports that the chief seat of infection in man is in and about the mouth, from there passing on into the thorax or abdomen. The actinomyces evidently become dislodged from their primary foci in the mouth and are passed on into the respiratory or digestive tracts.

The crypts of the tonsils prove to be a frequent nesting place for these fungi. In looking over the tonsils removed from one hundred patients, mostly children, Dr. Grosvenor finds the actinomyces in the crypts of the tonsils from fourteen cases. Here the fungi increase in number and size, crowding aside the walls of the crypts and by their irritation stimulate a great proliferation of the lining epithelial cells, with finger-like columns or masses of cells crowding into and even surrounding islands of lymphoid cells. This proliferation of epithelia forms a bulwark of protection against the invasion of the actinomyces into the tonsillar tissue. Immediately surrounding the fungi in the crypts are found many groups of swollen leucocytes with granular or fragmented nuclei. Such are the findings in the study of a large number of sections from the tonsils of the fourteen cases. Typical sections of these cases were demonstrated to the Society by the microscopic-stereopticon.

DISCUSSION.

DR. O. T. FREER examined the slides shown by Dr. Grosvenor with the microscope and saw characteristic ray fungi, so that Dr. Freer is convinced of the correctness of Dr. Grosvenor's findings.

DR. J. C. BECK thought that the fact that Dr. Grosvenor studied these cases with Dr. LeCount made this contribution valuable, although it is astonishing that so many cases of actinomycosis were found. If such a state of affairs really existed there ought to be more cases of actinomycotic infection of the neck. The epithelium lining these crypts is, as a rule, very much degenerated and helps to form a mass, which fills in the crypts. The leptothrix is frequently found in these masses and should not be mistaken for the actinomyces.

DR. H. KAHN enquired as to the relative age of the patients, their occupations and whether any cultures had been made from the tonsils; whether the cases had been selected or represented the average case.

DR. ANDREWS presented a case of disease of the tongue he had seen some years ago, which was later found to be actinomycosis. When he saw the case, the tongue was swollen, deeply furrowed, indurated and painful. He was unable to ascertain the cause of the trouble at the time, but the case finally came under the care of Dr. Tenney, who made a diagnosis of actinomycosis. Under Dr. Tenney's care the distressing symptoms had entirely disappeared although the tongue is still furrowed and shows some evidence of disease.

DR. A. C. TENNEY said that the condition of the tongue in this case was extremely distressing. There were many deep furrows, it bled easily and seemed to be covered with granulation tissue, presenting an appearance which had led to the diagnosis of tuberculosis and also of malignant disease. When he first saw the case, he was convinced that it was one of overgrowth of granulation tissue such as is seen in the conditions classed under the head of granulomata—syphilis, tuberculosis, actinomycosis, and the early invasions of malignant growths. Syphilis was excluded by the history and the fact that a long anti-specific treatment had availed nothing. Tuberculosis was excluded by the lack of secondary infection, absence of fever and other symptoms. Actinomycosis was suggested by the nodules in the salivary ducts, which it has been shown offer the least resistance, after the tonsil, to this disease. In this case the invasion was very apparent and Dr. Tenney thought it was a case of salivary lithiasis. However, there were also nodules in the glands which pointed to a possible actinomycosis. Dr. Adolph Gehrmann examined the specimens and found the first and second to be negative. Then the surface of the tongue was scraped in the morning, before anything had entered the mouth, and the actinomycetes were found in the scrapings. Another confirmatory sign was that when the patient was under alterative treatment she improved, while under mercurial treatment she suffered. Under mixed treatment there was no change. The problem was how to give her sufficient iodine to control the condition without getting any of the deleterious effects of the mercury, potash or sodium. Therefore, he resorted to the internal administration of iodine in organic combination and the patient has been kept in a very comfortable condition. The tongue is now fairly smooth, although there is still some infection present. The local treatment consisted in the application of potassium iodide by electrolysis. When this failed to give the desired results, he resorted to the use of copper with a mild galvanic current. Under this treatment, covering a period of about six or eight months, the general health of the patient improved and the local condition is markedly better. The patient is clinically well.

Speaking of Dr. Grosvenor's paper, Dr. Tenney said that Dr. Grosvenor evidently assumed that the tonsil is a resisting organ. His observation would lead him to assume the opposite attitude—that the tonsil has the least resistance of any, because the crypts furnish a splendid culture-ground in which the actinomycetes develop to such an extent that they assume the red formation and sub-

ject the patient to the danger of systemic involvement. The great danger in these cases is extension to the intestinal tract and lungs, and he wondered whether a case of tuberculosis reported by Dr. Grosvenor was not one of actinomycosis of the lung. Osler says that when one finds abscesses forming sinuses, the pus containing white or yellowish bodies, actinomycosis should be suspected. It is important to make an early diagnosis of actinomycotic infection in these cases, so that when they come to the specialist and the tonsil is the primary seat of the disease, a tonsillectomy may be done immediately, thus saving the patient from systemic infection.

DR. GROSVENOR in closing urged that the members make an examination of his microscopic slides, inasmuch as the details could not be seen so well in the lantern slides. He has been in the habit for ten years of working up microscopically all the tonsils which he removed himself. He had noticed these fungi in the tonsils and had regarded them as actinomyces, without, however, taking time to study the subject. However, when careful examination was made, Dr. Grosvenor found actinomyces in the crypts of 14 tonsils out of 100 cases studied. Most of these patients were children or young adults. He did not know that these were cases of actinomycosis until after the tonsils had been removed and examined. Therefore, he did not pay so much attention to the clinical phase of the subject. However, in looking up the history, he found that in every case there had been a severe tonsillitis a month or two before the removal of the tonsils, and that there had been previous attacks. Metschnikoff and others have considered the actinomyces related to the tubercle bacilli because branching forms of the latter have been found in sputum, and some observers have gone so far as to say that the tubercle bacillus is one of the stages of the actinomyces. The tonsils are the best incubators for bacteria of all kinds. Jonathan Wright, in 1904, showed the tonsils themselves did not become involved in the actinomycotic process, but that systemic involvement may occur.

Development and Structure of the Temporal Bone. By GEORGE W. BOOR, M. D.

DR. BOOR gave a lantern slide demonstration illustrating the state of development of the temporal bone during different periods of life from the ninth month of fetal life to the adult bone. Also several sections of adult bones showing the relations of the various parts. The young bones showed the exit of the facial nerve opposite the middle of the annulus tympanicus and the danger of its

being injured if the ordinary incision for mastoiditis were made in early infancy. They also showed the absence of a bony external auditory canal. Sections of the young bone showed the location of the antrum tympanicum wholly above the horizontal line running along the lower border of the zygomatic process, but section of the bone from a child 2 years old showed that the antrum had assumed its adult position below the zygomatic process.

The absence of the mastoid apophysis was shown in the young bones. Attention was called to the direction in which the annulus tympanicus developed, which was not outward, in a direction at right angles to the plane of the ring, but rather nearly in the plane of the ring, the development proceeding most rapidly at the anterior and posterior tubercles and at the lowest point of the ring. In cases where this last point of development did not proceed as rapidly as the others there is left a congenital defect in the anterior wall of the bony external auditory canal.

The location of the petro-squamous suture was shown as it runs through the tegmen of the antrum and tympanum and just below the antrum tympanicum on the outer surface of the bone.

DISCUSSION.

DR. GEORGE E. SHAMBAUGH pointed out that this demonstration of the developing temporal bone made quite clear a number of conditions well known clinically. One of these is the readiness with which an otitis media in an infant produces changes back of the auricle with the frequent development of a sub-periosteal abscess. This is accounted for by the fact that the antrum tympanicum in an infant lies very close to the outer surface of the temporal bone. The bony shell of the antrum in addition to being very thin is quite porous. The petro-squamosal suture in the infant makes still more free the communication between the interior and the outer surface of the bone. These anatomical conditions also explain why the simple Wilde's incision accomplishes so much more in an infant than it does in an adult. In fact by a simple Wilde's incision one has often the result of a Schwartz operation in an infant.

Another clinical fact which is explained by the anatomical preparation exhibited, is that in an infant any manipulation of the outer ear causes a great deal of pain in cases of acute otitis media, whereas in the adult this does not occur. The explanation lies in the fact that in the infant there is no bony meatus and the membranous part of the external meatus is attached to the os-tympanicum to which the drum-membrane is also attached, and any manipulation

of the auricle is bound to disturb the structures at the bottom of the canal, which are inflamed in acute otitis media.

DR. BOOR in closing stated that in order to enter the antrum through the petro-squamosal suture it is necessary to pass in an oblique direction upward, that passing directly in a horizontal plane enters often below the antrum.

Histo-pathology of Ethmoiditis. By J. C. BECK, M. D.

DR. BECK demonstrated by means of microscopical slides thrown on the screen the histo-pathology of chronic ethmoiditis with special reference to the paper read by Dr. Marquis at the last meeting, in substantiating the fact of there existing at least two distinct pathological types of the disease. To some members, not being convinced of the existence of the pathological entity as the hyperplastic form, which has been so thoroughly studied by Uffenorde abroad and Skillern in this country. Dr. Beck believed that he could demonstrate conclusively as to the existence of this form of ethmoiditis. Not only pathologically, but certainly clinically, most observers have seen ethmoidal disease with and without the presence of pus. Polypi may and do exist in both types of ethmoidal disease, but the polypi also differ in their histo-pathological consistency. The distinction of these two forms of ethmoiditis is also important from the therapeutic point of view, as well as the course of the affection. The one great difference in these two processes is essentially this: that in the suppurative form we have an inflammatory condition with the increase in the tissues due to such changes, including the epithelium, sub-epitheal tissue, the areolar tissue and blood vessels. The glands are not much destroyed early in the process. The bone is frequently involved in the inflammatory process and later often becomes necrotic while in the non-suppurative form the increase in the tissue is principally a degenerative process of a mixomatous type. Here the glands are markedly changed in atrophy. Inflammation is not present to any degree. There are also various degrees of changes in both the varieties, as Dr. Freer has mentioned at the last meeting of the A. M. A. The changes are a matter of degree of either inflammation and degeneration and destruction. As to the etiological factors, Dr. Beck could say nothing positive, but was inclined to believe that both varieties were due to a process of infection. In the non-suppurative form there existed most probably at one time infection which was of a lower form of micro-organism and this continued as a low grade of inflammation

and degeneration. That deflection of the septum and ridges on the same, which come in close contact with the middle turbinal, may act as an irritative cause or shut off the ventilation and drainage of the ethmoidal region and bring about the so-called hyperplastic changes with the whole coterie of symptoms can easily be accepted, as Uffenorde and others show.

The specimens shown were as follows:

LOW POWER ONE-THIRD.

A.—(HYPERPLASTIC) NON-SUPPURATIVE ETHMOIDS: *Case 1.*—Early involvement. 1.—Middle turbinal. 2.—Uncinate process. *Case 2.*—Later involvement. 1.—Polypus. 2.—Middle turbinal. 3.—Ethmoidal curetments. *Case 3.*—Previously operated and re-operated. 1.—Polypus. 2.—Remains of middle turbinal. 3.—Ethmoidal curetments.

B.—SUPPURATIVE ETHMOIDITIS: *Case 1.*—Three months' standing. 1.—Middle turbinal. 2.—Ethmoidal curetments. *Case 2.*—Five years' standing suppuration. Previously operated upon and re-operated. 1.—Polypus. 2.—Middle turbinal. 3.—Ethmoidal curetments.

HIGH POWER ONE-NINTH.

NON-SUPPURATIVE: 1.—Polypus. 2.—Middle turbinate. 3.—Ethmoidal curetments.

SUPPURATIVE: 1.—Polypus. 2.—Middle turbinate. 3.—Ethmoidal curetments.

Dr. Beck stated that the close study under the microscope would bring out the points made much better than when these preparations are thrown on the screen and that in the near future he would present this subject more advantageously with illustrations.

DISCUSSION.

DR. FREER said that Dr. Beck's specimens were a beautiful display of the pathological histology of ethmoiditis and were a valuable confirmation of what had been found clinically in operations. The proof of the existence of chronic inflammatory changes in the bone, by Dr. Beck, seemed especially important to Dr. Freer.

DR. BALLENGER said that he has always believed that the suppurative and non-suppurative types of ethmoiditis had the same etiology. In the suppurative type suppuration is present because the infection is more virulent. In the hyperplastic type suppuration is absent because it is a lower grade of infection. He believes the two conditions call for the same treatment although the non-suppurative may not require as radical treatment as the suppurative type.

DR. BECK in closing stated that various conditions, such as ridges, spurs, deflections, and the like, cause an irritation which is followed by an inflammation, but that is not the sole difference between the suppurative and non-suppurative types of ethmoiditis. The non-suppurative type is a degenerative process of the mucosa in which by pressure only will there follow changes in the bone. The suppurative variety is an infectious process which eventually results in bone necrosis. In one extensive treatment will lead to chronic sup-puration of the surface, whereas in the non-suppurative type possibly a middle turbinectomy will prevent further degenerative changes and result in a cure.

DR. SHAMBAUGH exhibited an apparatus for trans-illumination of the mastoid. This consisted of a small bronchoscopy lamp on a stiff holder about six inches long. The holder is covered by a heavy rubber sheath, from the end of which the lamp projects. The rubber casing is large enough so that when the lamp is placed in the external meatus the casing will occlude the outer opening of the meatus and prevent the escape of light along the walls of the canal. Without this occlusion of the meatus, the illumination of the mastoid would often be obscured by the escape of light along the wall of the meatus.

He believes that this method of transillumination of the mastoid by placing the lamp in the external meatus will prove superior to the method described several years ago by Dr. Andrews, where a lamp is placed over the mastoid while an inspection of the meatus is made.

Dr. Shambaugh pointed out that transillumination of the mastoid has distinct limitations, just as the same test when applied to the nasal accessory sinus. In the first place, the degree of illumination of the normal mastoid depends on the extent to which the process is supplied with pneumatic spaces. In a process free from air cells, the illumination will be absent. Fortunately, the type of process found on the two sides is usually the same, so that if one mastoid is pneumatic the other will be too. The comparison between the two sides when disease is suspected on one side, will therefore be of great assistance. In cases of chronic suppurative otitis media the mastoid is frequently the seat of osteosclerosis with an absence of pneumatic cells. Here the mastoid will of course be dark. In these cases, examination of the ear by other means will perhaps give us more definite clues as to the existence of conditions which may lead to serious complications and for which an operation is indicated.

It would seem that this method of examination will be of greatest aid in acute cases of unilateral otitis media, where there is an absence of the classical symptoms of mastoid abscess, such as the characteristic change in the external meatus or the development of tenderness over the mastoid, but where especially the persistence of discharge suggests a mastoid abscess. The presence of a shadow on the mastoid in the early stages in this type of case can not be accepted as a positive indication for an operation because the occurrence of congestion in the mastoid cells usually present in all cases of severe acute otitis media, will also produce a shadow even in the absence of any softening of the bone.

The lamp requires of course a rheostat and a suitable cable. The entire apparatus is simple, and can be adjusted by any one, or it can be secured complete from the firm of A. B. Mueller, of this city.

DISCUSSION.

DR. J. HOLINGER thought that this method of examination would prove to be of value in chronic cases of mastoiditis.

DR. A. H. ANDREWS said that there are many pathological conditions and some normal ones which will show a shadow in the mastoid. It is not always easy to interpret the findings. He has watched acute cases and has seen a shadow come as the case progressed and disappear as the case recovered. A shadow, he said, is not always an indication for mastoid operation. In the cases that seem to be passing from the acute or subacute into the chronic stage, where the patient complains little, but does not progress as he should, transillumination is a very valuable addition to other methods of examination of the mastoid, but the findings in all cases must be interpreted in the light of experience and reason.

DR. SHAMBAUGH states that he believes the method will be of more positive assistance in the acute cases verging on what might be termed a subacute condition, but without positive evidence of mastoid abscess. An article by Gustav Dintenfuss in the last number of the *Arch. f. Ohren.* discusses this method of transillumination of the mastoid.

In the case of chronic suppuration from the middle-ear, Dr. Shambaugh suspects that we will be able to place more confidence in other methods of examination to detect the existence of involvement of the temporal bone, with or without the invasion of epithelium, from the meatus and formation of cholesteatoma, which constitutes our chief indication for a mastoid operation, provided no

symptoms of serious complication are present. We, of course, recognize now that a larger number of cases of chronic suppurative otitis media where there may be periods of acute exacerbation of discharge associated with each fresh coryza, may not in themselves be any more dangerous to the individual than the attack of coryza, provided of course the disease is one that involves the mucous membrane alone and does not extend to the bony structure.

DR. ANDREWS feared that the last statement might give the general practitioner too great a feeling of security in allowing cases of chronic suppurative otitis media under his care to run on indefinitely, employing local treatment. Chronic suppuration in the ear is far too serious to be taken lightly by the patient or the practitioner and it would be a mistake to allow the impression to go out that these cases are not serious.

DR. SHAMBAUGH did not wish to convey a wrong impression regarding the situation in these cases of chronic suppurative otitis media. The point he wished to express was simply this, that we are now able to make a rather sharp distinction between cases of chronic suppurative otitis media where the process is limited to the mucous membranes and those where the bone itself is involved. Whereas in the latter cases we recognize a process that may at any time lead to serious complication, in the former case where the process involves merely the mucous membrane we do not fear any sudden complication. The statement made years ago by Dr. Wilde that in chronic suppurative otitis media we never can tell how, when, or where the process may end, we restrict now to those cases where the process has invaded the temporal bone, and it is therefore in these cases where we are justified in advising a radical mastoid operation. So long as the disease does not extend beyond the mucous membrane of the middle-ear no complication need be feared and no radical mastoid operation is justified. It is one of the triumphs of modern otology that to-day we are able to differentiate between these two classes of running ears.

NEW YORK ACADEMY OF MEDICINE.

SECTION ON LARYNGOLOGY AND RHINOLOGY.

Regular Meeting, October 26, 1910.

JOSEPH H. ABRAHAM, Chairman.

(Continued from page 130, February, 1911.)

A Case of Sarcoma of the Nose Operated on by the External Method. By T. J. HARRIS, M. D.

This lady has kindly consented to come here to-night in order to show one or two features of interest. She is 35 years of age and first presented herself for treatment last June, with a history of repeated attacks of nose-bleed and increasing nasal obstruction for two months. No specific history. Had never been ill. Examination of the nose showed complete obstruction. The tumor which could hardly be differentiated from polyps, suggested breaking-down tissue. It bled on being touched. A tentative diagnosis of malignancy was made, and with the thought of removing it thoroughly the patient was sent to the hospital. In two or three days it was decided to do the so-called Boeckel operation. This consists of three incisions—one from the inner canthus of the eye, a second from the ala to the nasal spine, and the third, from one inner canthus to the other. This with temporary resection of the septum gave a complete exposure of the sphenoidal and ethmoidal regions, and revealed two masses, one attached to the inferior turbinate body and the other to the ethmoid. Much of the bone had been absorbed. The two growths were completely cleaned out. After the growths had been cleaned away, pus poured from the sphenoid and frontal sinus. This clearly pointed to involvement there, and the frontal sinus was opened by the usual incision for the Killian operation. The sinus contained none of the tumor growth, but had granulation tissue in it. It was thoroughly cleaned out and the wound closed. The tissue was sent to Dr. Wright for examination at the time of the operation, and the report then was that it was possibly sarcoma. A later report, made after he had had time to study the specimen, stated that while there were distinct elements of sarcoma present, there was some doubt in regard to the condition, and that it would be advisable to put the patient under specific treatment. This was done, and she has had a full course of iodide of potassium. The

patient was presented for several reasons: 1. To emphasize the view that a thorough operation should be performed, even if the pathologist gives a reserved opinion as to malignancy—where the picture is that of a malignant growth it should be cleaned out completely. 2. To raise the question of the best procedure. This is not a condition for intra-nasal operation. The operation performed exposes the ethmoid and sphenoid very thoroughly; the only other operation which might be suitable is the so-called Moure operation, which makes a great cavity reaching from the malar eminence, and which afterwards allows the cheek to fall back. That, he claims, is more effective in exposing tumors and growth far back. 3. Consideration of the origin of this tumor. This is an interesting question—where did this so-called sarcoma of the nose spring from? Epitheliomata are apt to come from the antrum of Highmore, but the ethmoid is a very common site for these growths.

DISCUSSION.

DR. CHAPPELL inquired whether if Dr. Harris had to treat such a case again he would give the iodide before operating.

DR. HARRIS replied that, as a rule, he believed every case that suggests the possibility of syphilis, even where it appears decidedly malignant, should have the benefit of specific treatment. In this instance, however, the case had not suggested syphilis to him, and he questioned whether if he had to repeat the matter he would think of doing so. It seemed to be only a pulp-like tissue, which had broken down and was of a malignant nature. Ordinarily, he would agree with Dr. Chappell, that iodide should be given before operation.

In reply to a query from Dr. Wilson as to whether he knew of any cases reported in literature as cured, Dr. Harris said that he had not recently paid attention to that point, but only to-day he read an article by an assistant in Moure's clinic who reported a number of cases extending over many years, cured by external operation. He himself had reported a case before the Section where the cure extended over six or eight years. There seems to be no question that these cases can be cured, when dealing with a sarcoma. It is a different matter when dealing with carcinoma.

Syphilitic Necrosis of Bone Complicated by Tuberculosis. Presented by T. J. HARRIS, M. D.

This man presented himself at the Manhattan Hospital with this nasal deformity. He gave a clear history of lues, and has a positive Noguchi. Examination revealed an obstruction on the right side, which resembled sarcoma. The turbinate is so swollen that he

can get no air of that side. The introduction of a probe shows extensive necrosis on that side. In addition to this luetic condition there is a distinct general pulmonary tuberculosis, and he gives a positive von Pirquet. He is under anti-specific treatment and has improved somewhat, but we have refrained from operation as he has been very weak and has run a temperature. The appearance is that of a malignant growth. It is a very unusual combination of the two conditions showing such a picture in the nose.

DR. EMIL MAYER said that this was the most interesting case that had been presented to-night. In view of recent therapeutic experience, it would seem most desirable that a very careful picture—both pen and drawing—should be made of the man's condition, and he should then receive nothing but an injection of 606, and be presented again at the next meeting of the Section. The case would present an excellent test of what would follow one injection of 606. He has seen patients whose condition was most dreadful, brighten up after receiving one injection and appear like a healthy normal person within an incredibly short space of time.

DR. DELAVAN said that before administering the Erlich treatment in this case it would be well to consider the effect of the co-existence of tuberculosis in the patient. It was questionable whether the case was really a desirable candidate for the test. Cases should be carefully selected since at the present time every patient so treated was a test case. He was not inclined to consider the patient under observation a particularly eligible one for the 606 treatment, as this was not the type of case which had usually been selected by those employing the Ehrlich method. It would certainly be interesting to know what would happen if the experiment were tried in such a case. Dr. Delavan said that the Ehrlich treatment was being used at the present time in several institutions in New York City. He had seen several cases that very afternoon under treatment in St. Luke's Hospital.

Dr. Simon Flexner, in company with Dr. Fordyce, has been conducting a highly interesting series of treatments at the Rockefeller Institute and has already accumulated a considerable and valuable experience. The speaker believes from what he has heard through others who have used it, that it may possess elements of considerable danger, owing to the fact that it is a preparation of arsenic of extraordinary potency and possessing qualities not entirely understood. The risks attending its use may be conjectural, experience may prove that they are not based upon any real foundation. Meanwhile, however, it seems desirable that if the remedy

possesses elements of danger, these should be recognized and that 606 should not be put to indiscriminate use. The ultimate results of the use of Ehrlich's fluid are not well known; it is desirable that they be demonstrated. He believes that other cases would present more favorable conditions for the test than the patient in hand, and suggests that the patient be referred to someone of expert practical experience in the treatment, for an opinion.

DR. ABRAHAM said that he had recently read a letter from Dr. Ehrlich to Dr. Joachim, saying that the remedy would be placed on the market in a few weeks. He had already suggested to Dr. Harris that it would be a good test-case for the remedy.

DR. MAYER begged to differ with Dr. Delavan, and repeated that he considered the case very well fitted for the 606 treatment. If the man had tuberculosis he certainly also had syphilis, and he should have the 606. The presence of the tuberculous conditions is no contra-indication for the treatment. At any rate, the patient would be relieved of one factor in his condition, and would then have only the tuberculosis to contend with, which would mean a great deal, of course. He was quite sure that he could get this patient this treatment by Dr. Goldenberg, the head of the department at the Mount Sinai Hospital, who has administered all the injections there, and who certainly would refrain from giving it if the pulmonary condition was any contra-indication. So far as he himself has seen, the cases which do best under the treatment are the far advanced ones, although he has seen much good result from the treatment of cases with initial lesions.

DR. HARRIS said that he had been particularly interested in Dr. Mayer's remarks, for the case presents considerable difficulty in deciding upon what treatment to pursue. The man is running a temperature, is quite weak, and has been at Liberty this summer for tuberculosis treatment. If any surgical work were done it would have to be very extensive, and he has hesitated to go ahead and do what would be required. If Dr. Mayer felt that the 606 treatment offered the man a chance he would be most happy to send him to Mount Sinai for treatment, as he would prefer not to attempt surgical treatment. Dr. Coffin and he have been trying to secure a supply of the 606, but have not been successful as yet.

DR. YANKAUER said that he has a case of mixed syphilis and tuberculosis under his care at present. The patient has a clear case of syphilis, with a couple of cavities in his lungs, and a lesion in the larynx and on the soft palate which resembles a tuberculous lesion, though it is difficult to say whether the tubercle bacilli found

were derived from the lesion itself or were coughed up from the lungs. This patient will be put under the 606 treatment as soon as he is ready for it.

DR. COFFIN said that he did not think we should have more regard for the treatment than for the patient. The case is almost typically like one reported by Dr. Carter to this section a few months since. He found that the fluctuating mass at the bridge of the nose connected with the frontal sinuses and contained necrotic bone and pus. Of course, such a patient must be in a run-down septic condition, and if not operated upon must probably go to the bad. He would not hesitate to give him the 606. It is a good case in which to put it to the test. It is a rotten case at the best and the patient must stand for a radical operation, or stand for the 606. Any person, he thought, who had the condition and understood it and the two methods of treatment would ask for at least a trial of 606.

Case for Diagnosis. By H. JARECKY, M. D.

Dr. Jarecky said that he had only seen the patient to-day for a few minutes at the Sydenham Hospital, and had him come to-night, as the members might be interested in the case. He is 51 years of age, married, and has children. He denies syphilitic infection. Up to fifteen years ago had been a moderate drinker. Five weeks ago he noticed a lump on the right side of the neck, with no pain, and no pain on swallowing. A section of the growth in the tonsil has been removed, which is a sort of cauliflower growth. The man suffers no dysphagia, and all the symptoms are negative, with the exception of the growth. The pathologist has not yet sent in his report on the specimen. Dr. Jarecky said that he thought the members might like to make a diagnosis before the pathologist sent in his report. It appears like an epithelioma to him, but someone had suggested sarcoma.

DISCUSSION.

DR. SIMPSON said that the case presented by Dr. Jarecky was evidently a malignant growth of some kind—it is a large cauliflower enlargement, and the gland is very large and tense. He should like to know whether Dr. Freudenthal considered it a proper case for the application of radium, or whether the enlargement of the gland constituted a contra-indication for radium. Would he be less confident of a cure in such a case.

DR. FREUDENTHAL, replying to Dr. Simpson, said that the case presented by Dr. Jarecky was not an ideal case for the application

of radium, as it has sometimes to be left in place for twenty-four to seventy-two hours, and it is a very difficult matter to get a patient to keep the radium in his mouth for any lengthy period. An hour or possibly two hours is as long as most of them will submit to, and for that reason he has given up the radium treatment in laryngeal affections. He saw no reason, however, why the radium treatment should not be tried, unless Dr. Jarecky preferred some other method. He could not say whether or not the glandular swelling constituted a contra-indication. The price of the radium which he uses is \$2,000. It is packed in the nose for two reasons—first, that it should not fall out; and secondly, that the patient should not take it out himself and dispose of it.

DR. MAYER said that the case presented by Dr. Jarecky was very similar to one which he had been watching for a week or so. The patient came to Mount Sinai clinic with a similar ulceration on the tonsil, and presented a report showing that it was composed only of inflammatory tissue. He learned also that a very small piece of the tonsil had been removed.

Not being satisfied with the report, Dr. Yankauer removed a larger piece of the growth for examination, going deeper than before, but the same pathologist reported that it was a sarcoma. In this case there was no involvement of the glands of the neck. If Dr. Jarecky's case proves to be a sarcoma, it would seem that the diseased condition has existed longer than the patient is aware of. The patient came complaining of the swelling of the neck, and incidentally the condition in the tonsil was discovered; that probably has existed for a long time, and the involvement of the glands is secondary. It means a more serious condition for the patient and a more serious operation. A report from the pathologist will probably clear up the diagnosis. The clinical aspects of the case would suggest a sarcoma.

DR. MYLES said that the point he wished to bring out was that some of the radium cases have been very unfortunate while under his care. One had caused no end of trouble afterward, contending that it made him worse. In Dr. Jarecky's case he would suggest making an incision in the neck and placing the radium for many hours on the base of the tumor. He thought such a procedure justifiable if it offered a reasonable opportunity to cure the patient.

Specimen of Tubercular Larynx. By W. FREUDENTHAL, M. D.

This specimen of tubercular larynx was removed from a man 49 years of age who had been sick for five years, both lungs being affected. Ten days ante-mortem he complained of severe pain in

the throat and hoarseness. Two days before he died he could not swallow anything at all, and even whispering was painful. At the autopsy there was found a perforation of the thyroid cartilage and an abscess as big as a cherry. A point that should be brought out in connection with the abscess-and pus-formation is that we may have to do more external surgery in the future than we do now. He has seen several such cases where the abscesses form suddenly. This patient might have been saved. There was no swelling outside.

Collar-Button in the Esophagus of a Child. By H. ARROW-SMITH, M. D.

A child, 3 years of age, was referred to me on August 1, 1910. She had always been delicate and in the summer of 1909 had an attack of infantile paralysis. During her convalescence, in October, 1909, the nurse-maid gave her a large, brass collar-button to amuse her. She promptly put it in her mouth and swallowed it. She was immediately seized with dyspnea and dysphagia, and regurgitation of fluids through the nose. The urgent symptoms subsided somewhat in a few days and the parents assumed that the foreign body had passed into the stomach. From this time she failed steadily, was unable to eat solids, and fluids only with difficulty. She had a severe cough, with frequent choking spells and became weak and emaciated.

With the idea that this debility was a consequence of her severe illness, and that her cough and dyspnea might indicate some tuberculous trouble, she was treated with tonics and sent out of the city. In the latter part of her illness the sputum contained blood and pus. On July 31, 1910, practically ten months after the button was swallowed, Dr. Eastmond located it by radiography at the level of the first rib. The child was in desperate condition but I determined on an attempt at extraction, which was made August 3, the patient succumbing before anesthesia was complete. It was impossible to pass the esophagoscope, by reason of the inflammatory swelling above the button, which, however, could be readily felt, and engaged in a hook. No amount of force could dislodge it.

The button was removed through an external incision post-mortem. It had partially ulcerated through into the trachea, and was also surrounded in part by a very tough encysting wall. With no regard to the amount of force used, it was dislodged with considerable difficulty. The celluloid back had disappeared.

Had extraction been attempted within a few days or even weeks, it would have been comparatively easy, and certainly successful.

True Papilloma of the Nasal Septum. By H. ARROWSMITH, M. D.
(Published in full in the February, 1911, issue of THE LARYNGOSCOPE,
page 85.)

DISCUSSION.

DR. MAYER said that the first case reported by Dr. Arrowsmith was one of the most interesting that had been presented, and he hoped it would be published in full, as it was very practical. Undoubtedly if the child could have been examined by the modern methods the foreign body could have been removed without any trouble at all. Foreign bodies do not become lodged within twenty-four hours or even a week so that they cannot be removed. Afterwards, it is a different question.

DR. NEWCOMB, referring to Dr. Arrowsmith's second case, recalled one of nose-bleed in an old man which he had seen in consultation with Dr. Crandall, where there was no reason to suspect a papilloma. Dr. Wright made a pathological examination in this case and pronounced it typical papilloma.

Exhibition of X-Ray Plate Showing Complete Bony Septum in Antrum Operated Upon by the External Route for Empyema.
By T. J. HARRIS, M. D.

DR. HARRIS said that some years ago there was a symposium presented before the Section on the proper method of approaching the antrum of Highmore, in which the writers strongly advocated the intra-nasal route. The arguments in favor of the simplicity of the operation appealed to him strongly and since then he has largely employed this method. This summer, however, a case came to him with all the symptoms of empyema of the antrum. Operation revealed the thickest bone he has ever met, and when this was chiseled through it revealed one of the smallest antrums he has ever seen. After cleaning out the cavity and removing the mucous membrane, he found himself in touch with a crepitant wall, and suspected that it was a septum. This was found to be the case, and a large secondary antrum was entered. After the operation he again carefully studied the X-ray picture, and close examination will show a demarcation dividing the antrum into two parts. He had not noticed this before operating, and doubted whether anyone else would have done so. His experience in this case would corroborate the views in a recent article by Luc in favor of the Luc-Caldwell operation. Much can be said for this operation, in spite of the arguments for the other, as only in this way can one be sure that the entire cavity is entered.

DR. ABRAHAM stated that he has now a case operated upon by the intra-nasal method, with a septum in the antrum showing two

very distinct cavities. If this had been operated on by the canine-fossa method there would be little left for support, for the patient has a very large cleft palate. At present the patient is doing very well, and a dentist is making a plate for him to wear.

DR. FREUDENTHAL said that a year ago he operated upon a case with Dr. A. Braun, and was struck with the smallness of the antrum. A diagnosis of empyema had been made by the radiographer also, but after opening up the antrum, neither pus nor granulations were found. There was, however, a protruding wall, and when this was broken through the real cause of the disease was revealed—namely, a dentigerous cyst.

DR. MYLES said that he had a remarkable experience some ten years ago with the Luc-Caldwell operation. A moderate-sized antrum was found anteriorly, which was partially obliterated by a large dental cyst. The nasal wall was removed as well as the outer one, and what was thought at the time to be a complete operation was performed. The wound healed up, but the patient continued to suffer from pain in the region and finally got into the hands of a general surgeon, who removed the superior maxillary bone and found a second small antrum near the pterygoid plate.

(To be continued).

Fetid Atrophic Rhinitis and its Oto-Cranio-Cerebral Complications.

COMPAIRED. *Rev. Hebdom. de Laryngol. d'Otol. et de Rhinol.*, May 21, 1910.

The various forms of otitis, whether atrophic, exudative, hyperplastic or suppurative, which are caused or kept up by fetid atrophic rhinitis, are always more serious and more insidious than those due to other causes. One of the characteristics of these affections is that they are nearly always bi-lateral. If there is suppuration, this is more fetid, the color is an unhealthy grey and the secretion is more persistent. In cases in which there is a serious cranio-cerebral complication, the development is more rapid than in cases resulting from a general infection, such as grip, measles or variola. The recovery from operations in such cases is more prolonged and the effort of cicatrization is tedious. In the treatment of such cases it is, therefore, important to give especial attention to the atrophic rhinitis and endeavor by every means to establish cleanliness and asepsis in the nasal cavities.

SCHEPPEGRELL.

1910

Index-Medicus and Digest of Oto-Laryngology

Note:—All titles marked with a * are abstracted under their respective numbers in the second section. All articles marked with a † have appeared as original papers in THE LARYNGOSCOPE and are referred to as such. Abstracts prepared by the collaborators of THE LARYNGOSCOPE are signed by their respective names. Author's abstracts are signed A. A. Abstracts signed E.D. have been prepared at the home office of this journal. Those signed Ex. have been published in other journals.

Authors are requested to notify us of errors or omissions.

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III. ACCESSORY SINUSES.

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DIGEST OF OTO-LARYNGOLOGY.

1

Traumatic Origin of Abscess of Nasal Septum.

ANDEREYA, *Deut. Med. Wchnschr.*, Jan. 27, 1910.

Andereya concludes from an observation of five cases of abscess of septum that such abscesses are mostly due to trauma, even if patient gives no such history. He distinguishes between the cases which demand resection of septum and those in which no such procedure is indicated.

3

Dislocation of Septum Through Mucous Polypi. Lateral Ethmoidectomy. Restoration of Normal Shape.

J. BROECKAERT, *Ann. de Soc. belge de Chir.*, April, 1910.

Man, 33 years old, has had progressive obstruction of right nasal fossa with frequent epistaxis and mucous discharge since two months. Edema of right side of nose since one and one-half years. Anterior rhinoscopy: The lumen of the right nasal fossa was reduced to a vertical fissure; the mucosa was red and granulous. On the turbinal, septum and floor of the nose there were small grayish-white sessile tumors. Examination of one of these showed the absence of large cells. Although the reactions for syphilis were negative, specific treatment was prescribed. Rapid recovery.

5

New Surgical Case of Papilloma of the Nasal Septum.

C. CALDERA, *Arch. ital. di Otol. Rinol. e Laringol.*, Jan., 1910.

The author reviews the literature of the subject and describes the clinical history and the histological data of one of his own cases.

LASAGNA.

6

Consideration of End-Results of the Submucous Resection of the Nasal Septum.

F. C. COBB, *Trans. Am. L. R. and O. Soc.*, April, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 74, Jan., 1910.

8

Results of the Operation of Submucous Resection of the Septum in Private Practice.

F. P. EMERSON, *Jour. A. M. A.*, Oct. 22, 1910.

The indications for submucous resection of the septum are thus classed by Emerson: 1. The mechanical indications for removal of redundancy, etc.; and 2, the clinical indications which are considered in his paper. Not every deflected septum he says is pathologic. It is the conditions resulting from the unequal ingress of air that cause the patient

to consult the physician. Resection alone is seldom indicated; the associated complications must be relieved with any operation. This functional restoration of abnormal conditions must be based on the study of each individual case and the septum operation may need to be supplemented by removal of cystic turbinates, etc. Any indication for operation must take into consideration the existing functional activity of the mucosa, the glandular elements and the question of drainage of the sinuses. He describes his own methods. In his cases, the Killian incision was employed, in no case sufficiently anterior to run the risk of a dropped nose. More, he thinks, depends on ample space between the middle turbinal and the cushion of the septum than on a perfectly equal intake of air anteriorly. The entire middle turbinal was not sacrificed in his cases, and the inferior turbinate also was not removed but trimmed on its lower border. Special attention was given to the sinus drainage. Though local anesthesia was used in a large percentage of his cases, he recommends it only in selected cases. In all, 62 patients were operated on and inquiries were made of all of them by letter as to the later conditions, whether breathing was free, and how much relief was otherwise obtained in various ways. Forty-five answers were received: all but 2 had free nasal breathing; 39 had no trouble since the operation; 43 said that they were completely or greatly relieved; 1 reported only partial relief, and 1 none at all; 1 patient reported a great deal of nervous reaction and 1 some scabbing from an anterior perforation. One patient reported an unfavorable effect on general health. In 5 there was no change in this respect and 39 patients were improved; one patient had hearing entirely restored; 15 had it improved and the rest had either had no impairment or it was unchanged. Emerson believes that, with proper modifications, the submucous resection is applicable to all forms of deformity, and, if the principle of the hollow cylinder is carefully preserved by leaving sufficient margin superiorly and anteriorly, the window resection when indicated gives the most satisfactory results in the whole field of nasal surgery.—*Ex.*

13

Oral or Nasal Method in Operation on the Nasal Septum.

HALLE, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, No. 7, 1910.

Almost all septum operations in which the oral method of Loewe is employed may be regarded as unnecessarily drastic and because of the unavoidable narcosis may also be regarded as dangerous. The operation is justifiable in children under 4 years whose septum must be operated, or in extensive plastic work and in large tumors. Insufficient technic is rather a contra-indication than an indication for the oral method.

SAMSON (KUTTNER).

14

Endothelioma of the Nasal Septum.

A. HEIMENDINGER, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 62, Heft. 3-4, 1910.

Two cases of endothelioma of the septum are reported and minutely discussed. The author cites a consensus of opinion that the septum is the

most frequent point of origin in the fossa for malignant tumors. This, the author claims, is the case in carcinoma and sarcoma but not in endothelioma.

The histologic findings of the two neoplasms described by the author were of such different appearance morphologically that, it only emphasizes the variability in the structure of endothelioma. GOLDSTEIN.

15

Abscess of Nasal Septum.

G. F. KEIPER.

Original contribution to THE LARYNGOSCOPE, p. 753, July, 1910.

19

Deviations of the Septum. Sub-Mucous Resection After Sub-Labial Rhinotomy.

LANNOIS and DURAND, *Rev. Hebd. de Laryngol. d'Otol. et de Rhinol.*, Oct. 1, 1910.

The authors believe that sub-mucous resection is a preferable method in most cases. When, however, the deviations are too marked or too extensive, especially when there is exterior deformity; or when extensive synechiae are present, or when there is an abnormal narrowness of the nasal framework or of the nasal openings; and especially when several of these unfavorable conditions are combined, then sub-labial rhinotomy, in which an opening into the nostrils is obtained by means of a long incision in the gingivo-labial cul-de-sac, is indicated. It is evidently a more serious operation, necessitating general anesthesia, is accompanied by considerable loss of blood, causes swelling of the face and compels the patient to remain in bed for several days. But it offers a large opening and permits the surgeon to complete the operation with safety and in such cases to obtain results which would be impossible by other methods. SCHEPPEGELL.

21

Some Observations on the Late Results Obtained by the Submucous Resection of the Nasal Septum.

O. A. LOTHROP, *Boston Med. and Surg. Jour.*, July 28, 1910.

Lothrop reports on fifty-nine cases seen two years after operation at the Massachusetts General Hospital. In most of these cases beneficial results were obtained. Where improvement was not gained, examination showed (in the order of their frequency): a failure to remove a high septal deformity or a thickened septum, opposite the middle turbinate; (b) a remaining basal spur, sometimes complicated with an adhesion across to the inferior turbinate; (c) an enlarged middle turbinate on the concave side, keeping the septum over; (d) perforations, giving inconvenience only on account of the scabbing.

His findings with regard to eight children in this series are interesting. Five were thirteen years of age, and the other three were ten, nine and seven years respectively. In five cases the tip of the nose was apparently

depressed and the alae broadened. The nose of one of the older children had remained undeveloped. In the seven-year-old child, whose nose had been fractured in infancy, there was an undeveloped and deformed nose with deviated septum and partial nasal obstruction. The nine-year-old child likewise had sustained a fracture of the nose some years before the operation. The mother stated that the nose was more deformed and broader across the alae. Examination showed a depression between the tip and nasal bones, together with a lateral displacement. The nasal bones were abnormally long in proportion to the cartilaginous part of the nose. Apparently, in these children, a sufficiently broad cartilaginous bridge had been left for support. After referring to the histological growth of the septal cartilage, he adds: "Accepting the evidence that the main growth is from the centers adjoining the ethmoid and vomer, resection would, in most cases, remove more than half of these centers. It is then evident that resection hinders or nearly checks the growth of the cartilage, while there is no retardation of the downward and forward growth of the remainder of the nose, particularly of the nasal bones.

MOSHER.

22

The Nasal Septum, Important Points in Anatomy and Submucous Resection.

O. A. LOTHROP, *Boston Med. and Surg. Jour.*, July 28, 1910.

A. Lothrop gives a clear and concise review of the anatomy of the septum, and mentions some of the forms of deflected septa, with a reference to the theories for accounting for these deviations. He then points out some of the difficulties the operator is likely to encounter in performing a submucous resection of the septum, and suggests how these can be avoided.

MOSHER.

23

Bone-Cyst of the Septum.

S. McCULLAGH, *Proc. N. Y. Acad. of Med.*, April 27, 1910.
Abstracted in *THE LARYNGOSCOPE*, p. 37, Jan., 1911.

26

Septal Spur Operation.

J. A. PRATT.
Original contribution to *THE LARYNGOSCOPE*, p. 849, Aug., 1910.

28

Primary Tuberculosis of the Nasal Septum.

RAYMON, *Rev. med. de la Suisse romande*, No. 3, 1910.

Woman, aged 40, without any other tuberculous area. A tumor, the size of a hazel-nut, was situated on the anterior part of the septum, filling the lumen of the nose. It was painless. There was no nasal discharge. Microscopic examination revealed characteristic giant-cells. The woman had been nursing a tuberculous patient.

In another case, a grey swelling, the size of a nut, penetrated from the septum into the choana. It was also painless, but a profuse nasal

discharge was present. Microscopic examination revealed also in this case the characteristic giant-cells. This nasal tuberculosis was not primary but concomitant with bilateral pulmonary tuberculosis and lupus of the nasal passages and upper lip.

After removing such tumors the author recommends the use of the galvano-cautery. Only sixty cases of nasal tuberculosis are recorded.

31

True Papilloma of the Nasal Septum.

R. B. SCARLETT.

Original contribution to THE LARYNGOSCOPE, p. 833, Aug., 1910.

32

Pathogenesis of Perforating Ulcer of the Nasal Septum.

F. SCHIFFERS.

Abstracted in THE LARYNGOSCOPE, p. 817, Aug., 1910.

34

Bilateral Incision of the Mucous Membrane in the Submucous Resection of the Nasal Septum.

S. SREBRNY, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 1, 1910.

The author recommends an incision on each side of the nasal septum in this operation and finds that perforations are not more frequent, while the time of operation is much shortened. He operates now in fifteen to forty minutes. The operative technic is minutely described. After the operation the nose is tamponed on each side with especial care as to the disposition of the tampons, these being removed in three days.—*Ex.*

37

Destruction of the Nose Due to Disease of the Septum, Especially Hematomata and Abscesses.

G. TRAUTMANN, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 3, 1910.

Trantmann discusses in detail the various pathological septal processes which can cause disturbances in the nose, internally and externally—tuberculosis, syphilis, rhinoscleroma, etc.

38

Anatomic Hereditary Peculiarities as an Etiologic Factor in Deflected Nasal Septa and Accessory Sinus Disease.

J. G. WILSON, *Med. Rec.*, Jan. 29, 1910.

Wilson is of the opinion that the accessory nasal sinuses do not at present subserve any specific useful purpose, but are to be classed among the disappearing or vestigial organs, which facts largely account for their susceptibility to infection. The presence of deviated nasal septa is probably equally common in all races, becoming pathologic only in those races which are congenitally narrow-nosed. The cause of congenitally narrowed air passages and deviated septa is primarily developmental, and finds its true explanation in the fact that the brain case is being developed at the expense of the bones of the face and olfactory apparatus.—*Ex.*

39**Surgery of the Middle Turbinate Body.**

A. ANDREWS, *Jour. of Ophthal. and Oto-Laryngol.*, Oct., 1910.

Abstracted in THE LARYNGOSCOPE, p. 125, Feb., 1911.

45**Epithelial Tumor of the Middle Turbinate.**

S. McCULLAGH, *Proc. N. Y. Acad. of Med.*, April 27, 1910.

Abstracted in THE LARYNGOSCOPE, p. 38, Jan., 1911.

47**Contribution to the So-called Bone-Cysts of the Middle Turbinate.**

R. H. SKILLERN, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, p. 254, 1910.

Abstracted in THE LARYNGOSCOPE, p. 914, Sept., 1910.

51**Complications Consequent to Adeno- and Tonsillotomies.**

S. M. BOURBACK, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, Jan.-Feb., 1910.

In seven hundred and fifty tonsillotomies Bourack observed three severe complications, and in fifteen hundred adenotomies, five. He enlarges upon such possible complications as: severe hemorrhage; lesions of surrounding tissues; and accidental, constitutional and infectious disease, such as fever, ear complications, albuminuria, reflex spasms of glottis, etc.

53**Post-Adenectomy. Accidents and Complications.**

V. DELSAUX, *Presse Oto-Laryngol. Belge*, No. 12, 1910.

The author advocates minute disinfection of the nose and nasopharynx for about eight days, preceding adenectomy and insists on most rigid surveillance of the patient. Even with these precautions he reports as post-operative complications a febrile condition simulating scarlet fever, traumatic angina, torticollis, etc. The patients are operated in the hospital and kept there until recovery is assured. An indispensable precaution is the examination of the naso-pharynx after recovery from narcosis to see that no tags or remnants remain to induce post-operative hemorrhage. The curettes used for operative should have a keen cutting edge.

GOLDSTEIN.

64**Complications of Adenectomy.**

G. DE PARREL, *Bull. de Laryngol., Otol. et Rhinol.*, April 1, 1910.

The author adds to an account of the known cases a rare, thus far unpublished, case of Grossard's. Death resulted eight days after the operation as a result of septic hemorrhage.

71

Necessity for the Removal of Adenoid Vegetation and Tonsillar Hypertrophy.

J. N. ROY, *Jour. de Med. et de Chir.*, Nov. 20, 1910.

The following conclusions are made:

"It is necessary, nay, indispensable, to operate upon patients with (adenoid) vegetations, in order to avoid:

1. Adenoidal progressive malnutrition.
2. Arrest of development of the bones of the face, and the thoracic cage.
3. Infections of the respiratory tracts generally.
4. The inconveniences of nasal stenosis, and the dangers from mouth breathing.
5. Infections of the ear, or deafness.
6. Reflex nervous affections.
7. The doubly serious complications of infectious diseases.
8. Delay in intellectual development.

It is equally necessary to remove hypertrophied tonsils, in order to avoid:

1. Infections of the respiratory and digestive tracts.
2. Affections of the ear.
3. The aggravation of a diphtheritic infection.
4. Reflex nervous affections.
5. And lastly infection of the glands of the neck.

WISHART.

77

A Little Recognized Consequence of Adenoid Growths.

E. SMITH, *Practitioner*, p. 67, 1910.

The author calls attention to the liberal secretion of thick and acrid mucus when the post-nasal catarrh is of long standing. He points out that this is a cause of gastric derangement very difficult to treat unless its cause is removed and that the naso-pharyngeal irritation is apt to excite a troublesome cough with copious expectoration.

The gastric derangement shows itself in loss of appetite, and vomiting of alkaline mucus. These symptoms together with the cough may not be accompanied by snoring during sleep and other common signs of adenoids.

TILLEY.

81

Adenoids and Phthisis.

E. WIKNER, *Hygieia*, p. 345, 1910.

Only in one of the twenty-seven cases was it possible to show the presence of tubercle bacilli.

KIAER.

86

Nasal Diseases and the Sympathetic Nerve.

M. BRESGEN, *Passow's Beitrage*, Bd. 3, Nos. 1 and 2, 1910.

The spread of the sympathetic system in the nasal mucosa, explains the many reflex conditions resulting from diseases of the nasal mucous membrane. Whether reflexes in different parts of the body are trace-

able to an irritation of the nasal sympathetic nerve may be ascertained by applying suprarenal extracts.

87

Relation of Nasal Disease to Hay Fever and Asthma.

C. G. CRANE, *Am. Medicine*, Sept., 1910.

Crane reports five cases which he believes support his view that hay fever and asthma are reflex neuroses caused in many instances by nasal disease. Therefore treatment of the nasal condition is indicated.

—*Ex.*

88

Connection Between the Optic Nerve and Nasal Diseases.

A. DE KLEYN, *Ned. Tij. voor Geneesk.*, Heft 1, No. 13, 1910.

The author draws the following conclusions: Affections of the frontal sinus and anterior ethmoid cells, without orbital affections and under normal conditions, have no effect upon the optic nerve. The same is true of suppuration of the upper maxilla. Inflammations of the sphenoid cells and of the posterior ethmoid cells are very serious in respect to the optic nerve. Enlargement of the macula is an indication for nasal operation; the cause of the enlargement is a circulatory and toxic one. In affections of the optic nerve of doubtful origin the posterior ethmoid cells and sphenoid sinus should be opened even if nasal examination reveals nothing pathological. It is wrong to assume that bilateral papillitis is usually due to constitutional causes; for unilateral ethmoid and sphenoid suppurations may cause affections of the optic nerve, and inflammation of the posterior accessory sinus may be bilateral.

90

Nasal Phenomena of Neurasthenia.

C. P. GRAYSON.

Original contribution to *THE LARYNGOSCOPE*, p. 1114, Dec., 1910.

92

Anaphylaxis and Internal Secretions in Connection with Hay-Fever.

C. HOFFMANN, *Zentralbl. f. Chir.*, June 11, 1910.

The main points in treatment of hay-fever are to check the functioning of the thyroid and to reduce the irritability of the nasal mucosa. Strumectomy is the most radical measure, but Roentgen-ray treatment may also prove effectual in checking thyroid hyperfunctioning. The irritability of the nasal mucosa can be combated by topical measures, by a constricting band around the neck, by injection of alcohol into the nerve or by severing the nerve, or by massage or cauterization of the nasal mucosa or other measures. His clinical experience has been very favorable with treatment based on these principles, the guiding idea being that hay-fever—pollen disease—is due to a special susceptibility to an alien albumin contained in the pollen of certain plants, plus thyroid hyperfunctioning.—*Ex.*

94

Neurasthenic Conditions Referable to the Nose and Throat.

W. H. JAMIESON, *Montreal Med. Jour.*, Aug., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 101, Feb., 1911.

97

Relation Between Facial Nerve and Diseases of the Nose.

A. DE KLEYN, *Med. Tijdschr. v. Geneesk.*, Vol. 1, No. 13, 1910.

The author draws his conclusions from a study of twenty-two patients. He thoroughly discusses the prognosis and treatment.

98

Influence of Cauterization of the Nose upon Cardiac Neurosis.

A. KOBLANCK, *Deut. med. Wchnschr.*, Feb. 24, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 538, May, 1910.

111

Reflex Nasal Neurosis.

C. M. STEWART, *Montreal Med. Jour.*, Aug., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1147, Dec., 1910.

120

Papilloma Durum of the Nose.

A. BLUMENTHAL, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 2, 1910.

Tumor the size of a small cherry situated at the junction of the vestibular membrane with the left inferior turbinate, in a man aged thirty years. Removal with snare. Article contains reference to all the other incidents of this rare occurrence in medical literature.

121

Case of Rhinoscleroma.

A. BRAUN.

Original contribution to *THE LARYNGOSCOPE*, p. 124, Feb., 1910.

122

Sarcoma of the Nose, with Presentation of Cases.

J. PRICE BROWN, *Can. Jour. of Med. and Sur.*, Jan., 1910.

This paper is an account of a clinic at which the writer presented six patients in each of whom he had diagnosed nasal sarcoma, and applied the treatment by the galvano-cautery, of which he is the vigorous exponent. An account follows of the discussion which ensued. In conclusion the author stated that his experience emphasized the following points:

- (1) In sarcoma of the nose the usual site of origin is in the soft tissues and not in the bony framework which supports them.
- (2) That the origin is in the form of a pedicle, which rapidly becomes sessile.
- (3) That as the sarcomatous mass enlarges and presses upon the surrounding mucosa abrasions take place, which are quickly transformed into adhesions; and these adhesions in time will become almost co-extensive with the disease itself.
- (4) That these adhesions never attain the vitality and virile power possessed by the pedicle. Hence, when once thoroughly destroyed recurrence does not take place upon the site of the adhesion.

(5) Recrudescence, however, frequently does occur in the region of the pedicle; and in view of this contingency this region should be kept under regular observation and control.

(6) When the nasal passage is filled with the sarcomatous growth, any attempt to discover the site of adhesions will at once produce hemorrhage. Hence, intra-nasal removal by the knife should not be attempted; but as gradual and systematic dissection out by the cautery knife, except in extreme cases, is always available, it should not only be encouraged but should be insisted upon.

WISHART.

126

Contribution to the Study of Rhinophyma.

L. CLERC, *Arch. ital. di Otol. Rinol. e Laringol.*, July, 1910.

An histological examination of fragments of neoplastic tissue revealed the fact that the characteristic and predominating portion consists of lymph-tissue, an interesting and peculiar phenomenon thus is found, due to the singular arrangement of the mononuclear lymphocytes, which give the tumor an appearance similar to a glandular lymph-organism. In a case of rhinophyma reported by the author, the conclusion is reached that it is a lymph-tumor. Syphilis, of course, must be considered, as one of the strongest etiologic factors.

127

Papillomata of the Nasal Fossae.

L. DELMAS, *Clinique*, Jan. 21, 1910.

The author deals at length with the pathology of the nasal fossae.

129

Indurated Chancre of the Right Nasal Fossa.

G. DUPOND, *Rev. hebdomadaire de Laryngol. d'Otol. et Rhinol.*, March 5, 1910.

Abstracted in THE LARYNGOSCOPE, p. 800, Aug., 1910.

131

Rhino-Scleroma: Report of Two Cases.

S. A. FRIEDBERG.

Original contribution to THE LARYNGOSCOPE, p. 828, Aug., 1910.

132

Diagnosis and Treatment of the Various Forms of Occluded Rhinolalia.

E. FROESCHEL, *Stimme*, Sept., 1910.

Report of five cases with a lengthy discussion of the symptom and therapy.

134

Lymphanigectasis-Myxoma of the Stroma of the Nose.

M. HAJEK and L. POLYAK, *Arch. f. Laryngol. u. Rhinol.*, Vol. 23, Heft 1, 1910.

This case was first described as multiple latent empyema of the accessory sinus: osseous blisters, exophthalmus and atrophy of both optic nerves. A full description of this interesting case follows.

135

Fibro-Sarcoma of the Nose Removed After Temporary Ligature of the External Carotid and Laryngotomy.

HARMES, *Proc. Roy. Soc. Med.*, Vol. 3, No. 5, 1910.

Tumor in man 47 years old, protruding into left orbit, antrum and naso-pharynx, but not into the temporal fossa. Operation shows that it was attached to the base of the skull from the anterior of the frontal sinus to the sphenoid sinus. To remove it a small portion of the lamina cribrosa and of the dura mater had also to be removed. The author emphasizes the importance of temporal ligature of the external carotids and laryngotomy, without which the patient would have probably bled to death.

137

Rhinophyma.

H. HOFFMANN, *Ztschr. f. Ohrenh., Rhinol. u. ihre Grenzgeb.*, Bd. 2, Heft 4, 1910.

Review of the various views of rhinophyma. The author also discusses the differential diagnosis and the etiology of this disease and indicates the different methods of treating emphyema. Also report of a case successfully treated.

140

Rhinophyma.

O. LANZ, *Nederl. Tijdschr. f. Geneesk.*, No. 16, 1910.

Report of three cases. In one the von Bruns operation was performed to relieve the swelling. In the more diffuse form decortication is indicated. The new skin quickly forms from the epithelium of the remaining sebaceous gland. If a local anesthesia—cocain-adrenalin—be used the hemorrhage is slight.

141

Pathology and Treatment of Mucous Polypi of the Nasal Fossae.

H. LAVRAND, *Rev. Hebd. de Laryngol. d'Otol. et de Rhinol.*, June 18, 1910.

Mucous polypi of the nasal fossae are not myxomata. They are inflammatory products following a chronic osteitis of the ethmoid. Consequently the treatment consists in their removal, followed by curetting the necrosed bone in order to prevent the reproduction of the neoplasms.

SCHEPPEGRELL

143

Malignant Disease of the Nasal Passage.

W. S. Low, *Lancet*, Oct. 1, 1910.

Stuart-Low reports seven cases to illustrate the rather frequent occurrence of sarcoma and carcinoma in these localities. He says that pain is not to be relied on as an indication of malignant disease in the nose. Increasing and persistent stuffiness, especially if unilateral, is an important point as regards diagnosis. Recurring and increasingly severe hemorrhage, especially if unilateral, is always a suspicious symptom. A combination of hemorrhage and increasing stuffiness is often a serious indication of the existence of a new growth. The mak-

ing of an early diagnosis is of great importance. It is imperative to make a thorough and systematic examination in all obscure cases of nasal disease, and to remove early a piece of any obstruction in the nasal passages for a pathologic report. It is of great importance when there is malignant disease to operate as soon as possible after a diagnosis has been made to secure a successful removal. It is advisable to adopt the canine-fossa route in operating for the extirpation of intranasal tumors. Innocent and malignant polypi are likely to coexist.—*Ex.*

145

Polypoid Sarcoma of the Nose.

F. C. MADDEN, *Practitioner*, March, 1910.

Under this term Madden describes a tumor whose structure is that of sarcoma but of such a low grade of malignancy as to produce comparatively little surrounding destruction, after a prolonged period of growth. Clinically, the sequence of symptoms appears to be polypous formation in both nostrils, leading soon to complete nasal obstruction; expansion of the cartilaginous portion of the nose, with marked hypertrophy of the overlying skin; and, later, marked thickening and infiltration of the columella and upper lip, with, finally, but only after a very chronic course, extension to surrounding parts.—*Ex.*

147

Contribution to the Study of Polypi of the Nasal Mucosa Called "Bleeding Polypi."

A. MALAN, *Arch. ital. di Otol. Rinol. e Laringol.*, July, 1910.

The author discusses the characteristic anatomic-pathological structure of the formation apropos of two cases. They are composed of connective tissue and vessels, not of granulomatous tissue. He designates them as fibro-vascular tumors.

153

Osteo-Chondroma of the Nasal Fossae.

E. J. MOURE and PIERRE-NADAL, *Rev. Hebd. de Laryngol. d'Otol. et de Rhinol.*, April 30, 1910.

The authors describe a case of this rare tumor which, in their patient, presented most of the symptoms of a post-nasal fibroid. The tumor, which had become so large that it had caused facial deformity and exophthalmos, was successfully removed by resection of the superior maxilla, the patient making a good recovery. The case reported shows that while many surgeons are prevented from operating on such cases on account of their almost malignant tendency, good results may be obtained even in cases in which the tumor has assumed large proportions.

SCHÉPPEGRELL.

154

Nasal Sarcoma in a Child of Three Years.

G. PALUDETTI, *Arch. Ital. di Otol., Rinol. e Laringol.*, July, 1910.

Sarcoma originated in the left nasal cavity and penetrated into accessory sinuses and base of skull causing metastatic formations in the

cervical ganglion. The rapidity of the development of the disease—one and one-half months from its first appearance to a fatal termination—is of interest.

167

Primary Lympho-Sarcoma of the Naso-Pharynx.

L. CLERC, *Boll. delle Mal. dell'Orecchio, della Gola e del Naso*, May, 1910.

Tumor occupied the whole naso-pharynx, penetrated the right tube and appeared in the form of a polyp in the external auditory canal. Operative intervention brought merely temporary relief; radium-therapy had at first, a favorable effect on the metastatic lymph-glands, which decreased somewhat in size, but could not prevent a fatal issue.

169

Etiology of Growths in the Naso-Pharyngeal Region.

A. GREIDENBERG, *Russ. Monatschr. f. Ohrenh.*, No. 3, 1910.

Three cases of fibromata of the naso-pharynx—varying in size from that of a pigeon egg to that of an apple—in young adults. Removal with galvano-cautery snare. Very slight hemorrhage.

170

Method of Removing Naso-Pharyngeal Fibromata.

T. GUTHRIE, *Lancet*, Oct. 29, 1910.

Detailed description of operative technic in dealing with these rare cases. It is similar to Brady's method save that the anterior nasal opening is widened through an intra-nasal instead of through an external incision.

183

Large Naso-Pharyngeal Fibroma Removed by Resection of Upper Maxilla.

L. TIXIER, *Trans. Soc. de Chir. de Lyon*, Feb. 13, 1910.

This large naso-pharyngeal fibroma filled the cavity, and the right nasal fossa and maxillary sinus, and occasioned frequent and profuse hemorrhage. Upon its removal the hemorrhage ceased.

184

Congenital Occlusion of the Choanae.

H. ABOULKER, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, Nov.-Dec., 1910.

A report of four cases, of which the first was a complete membranous closure of one side and a partial closure of the other side. Opening was made with the galvano-cautery which, however, could not be maintained because of the difficulty in keeping the drain in place to bring about epidermization. The occlusion recurred. The three other cases were of osseous formation. Two were operated upon successfully by means of the drill, the third refused operation.

GOLDSTEIN.

186

The Wassermann Reaction in Rhino-Laryngology.

L. ARZT and B. GROSSMANN, *Monatsschr. f. Ohrenh.*, Vol. 44, p. 341, 1910.

From the examination of fifty-two cases the authors conclude: (1) The Wassermann reaction is of great value in rhino-laryngology. (2) Serum diagnosis does not give any evidence of lues as a factor in the causation of ozena but on the contrary enables us to exclude this condition as a causative factor.

YANKAUER.

189

Early Forms of Ozena.

E. BAUMGARTEN, *Orvosi Hetilap*, No. 5, 1910.

Published in the *Archiv. für Ohrenheilkunde*, Band 22, Heft. 3, 1909.

190

Visual Disturbances Due to Diseases of the Nose.

E. BAUMGARTEN, *Orvosi Hetilap*, No. 4, 1910, and *Monatsschr. f. Ohrenh., u. Laryngo-Rhinol.*, Bd. 44, Heft 9, 1910.

The author reports seven cases in which serous and suppurating diseases of the sphenoid sinus, bulbous swellings of the middle turbinate and luetic ulcers caused acute and chronic visual disturbances,—papillitis, scotoma, amblyopia, and even blindness. By opening anterior sphenoidal wall and removing pathological causes normal conditions were obtained.

192

Interesting Case of Traumatic Anosmia from a Medico-Legal Standpoint.

BIASOLI and MASUCCI, *Arch. ital. di Otol., Rinol. e Laringol.*, Sept., 1910.

The authors were called upon to attest to the acuity of the olfactory sense in a young man injured in a fight. The man also claimed to have lost his gustatory perception. Tests of the following nature were made: The olfactory region was bandaged with a hydrogen sulphate solution without the slightest disagreeable sensation. Cauterizing the nose with trichloroacetic acid or the essence of mustard produced only delayed and then only very slight effects. As to the gustatory sense; the four fundamental perceptions were apparent, but the odor of flowers in a sugar solution gave only a vague perception of sweetness. The authors show the difficulties this question presents and that at best only the degree of loss not simulation can be determined unless the patient be observed for a long time.

197

The Relation to the Eye of Diseases of the Nose, Throat and Ear, the Mouth and Pharynx. (Symposium.)

J. PRICE BROWN, *Dom. Med. Monthly*, March, 1910.

The literature of rhinology and laryngology contains few references bearing upon the relation of the mouth and pharynx to diseases of the eye, but ophthalmic literature is more productive. Optic thrombosis from carious teeth, orbital phlegmos from pharyngitis, temporary concentric narrowing of the field of vision following applications of the cautery in the naso-pharynx, are among the cases noted.

WISHART.

198

The Relation to External Eye and Orbital Disease of Diseases in the Nose, Throat and Ear. (Symposium.)CLOIN CAMPBELL, *Can. Proc. and Rev.*, Oct., 1910.

The bacteriology of the eye is doing much to point to cause and treatment for the similarity of the fauna of the eye with that of the nose and mouth is striking. The relation of the staphylococcal infection of the conjunctiva and cornea with adenoids and nasal suppuration is well known. The pneumococcus by far the most important organism in the etiology of hypopyon ulcer, and of disease of the lachrymal sac, and a frequent cause of conjunctivitis is to be found in the mouth, whereas Axenfeld was able to find it only twice in the healthy conjunctiva. Whether tuberculosis of the sac originated more frequently by blood infection or from the nose or conjunctiva is unsettled. A case is referred to where a boggy lachrymal mucocele and a lupus involving the anterior half and the floor of the nose co-existed. Tubercle bacilli existed in the turbinal sections, but the excised sac showed only the changes of simple inflammation. Infection had not taken place although disease had existed for months. Another case is noted of a child of ten where a thrombophlebitis ophthalmica was shown post mortem to be due to diseased posterior ethmoidal cells.

WISHART.

200

Nasal Hemorrhage due to High Blood-Pressure.G. H. COCKS, *Proc. N. Y. Acad. of Med.*, April 27, 1910.Abstracted in *THE LARYNGOSCOPE*, p. 42, Jan., 1910.

202

Fetid Atrophic Rhinitis and its Oto-Cranio-Cerebral Complications.COMPAIRE, *Rev. hebdomadaire de Laryngol. d'Otol. et de Rhinol.*, May 21, 1910.

The various forms of otitis, whether atrophic, exudative, hyperplastic or suppurative, which are caused or kept up by fetid atrophic rhinitis, are always more serious and more insidious than those due to other causes. One of the characteristics of these affections is that they are nearly always bi-lateral. If there is suppuration, this is more fetid, the color is an unhealthy grey and the secretion is more persistent. In cases in which there is a serious cranio-cerebral complication, the development is more rapid than in cases resulting from a general infection, such as grip, measles or variola. The recovery from operations in such cases is more prolonged and the effort of cicatrization is tedious. In the treatment of such cases it is, therefore, important to give especial attention to the atrophic rhinitis and endeavor by every means to establish cleanliness and asepsis in the nasal cavities.

SCHEPPEGRELL.

203

Historical and Critical Review of Clinical Pneumodography-Rhinometry.A. COURTADE, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, March, April, May and June, 1910.

In an exhaustive monograph C. describes the possible value of pneumodography, an apparatus devised by him to record the volume of breath in inspiration and aspiration and its practical application.

GOLDSTEIN.

206**Changes in the Nose After Widening the Palatal Arch.**

L. W. DEAN, *Jour. A. M. A.*, Nov. 26, 1910.

Dean after referring to experiments made to show the increase in the breathing space of the nose in green skulls after widening the palatal arch, and referring also to the skepticism of some as to the corresponding effect in the living subject, reports the case of a patient in whom measurements were made which show the efficacy of the method. The measurements were made by one of his colleagues, all under the same conditions, viz., with the mucous membrane shrunk by continuous application of cocaine, 20 per cent., and adrenalin 1 to 1,000, for twenty minutes. These measurements corroborate the measurements that were made on the green skull and reported to the Section on Stomatology of the A. M. A. The subjective improvement of the patient was of the very best, and the objective improvement was also equally good. The patient is now a nasal breather day and night and the general health is better. He is wonderfully improved also mentally.—*Ex.*

207**Naso-Pharyngeal Origin of Chorea.**

S. L. DE PONTIERE, *Jour. of Laryngol., Rhinol. and Otol.*, Sept., 1910.

The author gives the pathogenesis of chorea as either due to neurosis or rheumatic infection. He admits the frequency of the rheumatic origin of chorea but also points out the frequent existence of the naso-pharyngeal sources of rheumatism. By removing tonsils and adenoids rapid and lasting success has been obtained.

208**Clinical Observations of Streptococcic Pyemia. Two Fatal Cases of Naso-pharyngeal Origin.**

DESHAYES, *Clinique*, Feb. 18, 1910.

In the one case removal of adenoids caused severe hemorrhage which was checked by tamponade. After this he was delicate and gradually septic pyemia developed. In the other case, a woman, 31 years old, swelling of the extremities was followed in two days by nasal obstruction to breathing, and in four days a pseudo-membrane developed in the nose. No changes in the pharynx. Serum was injected. Loeffler's bacilli found. Death from pyemia. The interesting thing about both of these cases is that the diphtheria attacked the nose alone.

212**Superficial Epithelioma on Lobe of Nose Rapidly Following Traumatism.**

DUBREUILH and PETGES, *Gaz. hebdomadaire des Sci. med. de Bordeaux*, May 8, 1910.

Patient aged 33 years, sustained a slight injury to the lobe of the nose, after which a hard lardaceous layer appeared, covering the whole surface of the lobe. This layer is covered with a thin transparent copper-like epidermis. In the middle, two round superficial ulcers are apparent. The body of the lobe appears to be the seat of the scleroderma.

Examination showed that this was a case of tubulated baso-cellular epithelioma of the rodent ulcer type. This variety of cutaneous epithelioma is very rare.

213

The Relation to the Eye of Diseases in the Nose, Throat and Ear.—Intra-ocular Disease. (Symposium.)

J. T. DUNCAN, *Can. Prac. and Rev.*, March, 1910.

The author presents a brief review of the literature bearing upon this interesting relation, with special reference to ethmoidal and sphenoidal affections producing optic neuritis and blindness, an enlarged turbinate producing neuritis, and the injection of a nasal polyp with carbolic acid ending in iritis, optic-neuritis and optic atrophy.

WISHART.

217

Study of Perforating Nasal Ulcer.

G. FIDAO, *These de Paris*, 1910.

Perforating nasal ulcer belongs especially to the cartilaginous septum of the nose. Prophylaxis consists in protecting the ulcers from toxic dust and all toxic influences. The lesion should be washed with solutions to loosen the adhesive dust and with such remedies applied as favor cicatrization.

220

Intra-nasal Measurements which indicate that Palatal Expansion Increases the Width of the Nasal Fossae.

E. E. FOSTER, *Ann. of Otol. Rhinol. and Laryngol.*, March, 1910.

Irregularity in the palatal arch and growth of the teeth may be either the cause or result of insufficient nasal respiration. By means of specially devised instruments innumerable nasal cavities were measured before and after corrective treatment of the palatal arch, and upon this the author bases his claim.

222

Rhinometric Study of Nasal Respiration.

R. FOY, *Ann. de Mal. de l'Oreille, du Larynx, du Nez et du Pharynx*, Feb., 1910.

Foy gives a detailed account of his studies on the means of measuring the permeability of the nasal fossae to air. He reviews the methods hitherto employed and indicates improvements in technic.

224

Nasal Tuberculosis—Two Cases, One Involving the Right Ethmoid Bone with Recovery After Operation.

O. T. FREER, *Ann. of Otol. Rhinol. and Laryngol.*, March, 1910.

Lupus of the nasal mucosa is peculiar to puberty and is limited almost wholly to women. True nasal tuberculosis occurs between the ages of 25 and 60 years, both in men and women. The first case, a woman, 25 years old who complained of occlusion of her right nostril, from which an odorless purulent fluid issued. Examination showed pale-red granulation projecting from the middle turbinate along the septum into the choana. Posterior rhinoscopy revealed irregular ulcerous tumors the

size of a hazel-nut which embraced the posterior end of the middle turbinate. They were removed and a microscopical examination made which disclosed giant cells but no tubercle bacilli.

After a few weeks crusts and polypoid granulations formed on the middle turbinate at the site of operation. Second operation. After some months the granulations reformed, showing an ethmoidal origin. The whole ethmoid sinus is thoroughly scraped. Tubercle bacilli are found. Complete recovery.

The second case, a woman aged 50 years, complained of bilateral occlusion of the nares and swelling of the external nose. Anamnesis and pulmonary findings negative. On both sides of the septum irregular swelling, partial fungoid granulation, extending to the inferior turbinate and forming adhesion. The swelling of the external nose is due to broadening of the cartilaginous septum. A specimen shows the presence of giant-cells and tubercle bacilli. Radical operation seems no longer advisable; so the obstructing granulations were removed and tuberculin injected.

225

Endocranial Complications of Nasal Origin.

W. FREUDENTHAL.

Original contribution to THE LARYNGOSCOPE, p. 60, Jan., 1910.

226

Diagnosis and Treatment of the Various Forms of Occluded Nares.

E. FROESCHELS, *Stimme*, Sept., 1910.

The author divides the nasal tone in speech into two groups: (a) the muffled tone, (b) the nasal twang.

The cause for muffled tone depends on mechanical obstruction in the naso-pharynx, such as adenoid vegetations, post-nasal polypus or adhesions between the soft palate and the posterior pharynx wall. The nasal twang is produced by changes in the nares, such as narrowing of the meatus, polypi, deflections of the septum, hypertrophy of the turbinates, etc.

Another type of change in nasal tone is caused by functional disturbances in the soft palate.

F. suggests for differential diagnosis the introduction of bent probes or similar instruments into the two nares until the tips touch the soft palate. When a functional change in the palate exists, the additional support given this muscle by the probes will radically improve the enunciation of certain test-words. In the latter class of cases vocal exercises are advised to correct the disturbances; in the former groups where obstruction to the nares or in the naso-pharynx exists operative measures are carried out to clear the passages.

GOLDSTEIN.

228

Nasal Obstruction and Pulmonary Tuberculosis.

O. GLOGAU, *Allg. Wr. med. Ztg.*, Nos. 16, 17, 18 and 19, 1910.

Nasal obstruction often aggravates pulmonary tuberculosis. If the pulmonary disease is still in its early stages, it may be greatly benefited by

nasal operation. Yet the author only advises operation if the nasal obstruction be extensive.

230

Significance of Wassermann Reaction in Rhino-Laryngology.

B. GROSSMANN, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, March, 1910.

Experiments on fifty-two cases prove the value of the Wassermann reaction in rhino-laryngology. However, by this means of examination lues could not be determined as the cause of simple ozena.

232

Collapse of the Ala Nasi and the Operative Cure.

M. HALLE, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 3, 1910.

The tissues responsible for the collapse of the ala nasi are the septal cartilage, the alar cartilage, the levator ala nasi muscle and occasionally the anterior floor of the nose.

The subluxation of the septal cartilage or the membranous septum has heretofore been disposed of by various prostheses, such as the dilators of Feldbausch and Schmidhulsen and the rubber rings of Guye. These H. claims are simply orthopedic relief-measures but do not dispose of the deformity.

When the alar cartilage is too sharply bent, so that it lies against the septum superiorly, H. dissects up the mucous border and removes sub-mucously a small part of the upper edge of the cartilage. Similarly a small portion of the lower edge of the alar cartilage may be removed if the deformity in it is reversed.

Where the cartilage is very soft and limp, Menzel recommends paraffin injection. Eckstein has suggested the introduction of a small triangle of silver wire, imbedding it in the vestibular tissues. Haller makes a small pocket laterally and introduces a small silver wire spring to support the alar cartilage.

Where cuboid thickening of the membranous cartilage exists, H. makes an incision at the junction of skin and mucosa, parallel to the free border of the membranous septum. The lower portion of the membranous septum is retracted outwards, the thickened portion consisting of sub-cutaneous and sub-mucous tissues and occasionally of cartilage is dissected out and the membranous tissues united by sutures.

GOLDSTEIN.

237

Epistaxis in its Relation to Various Constitutional Diseases.

H. HAYS, *N. Y. Med. Jour.*, Sept. 24, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 116, Feb., 1911.

251

The Social Hygienic and Economic Aspect of the Nose.

J. J. KYLE.

Original contribution to *THE LARYNGOSCOPE*, p. 24, Jan., 1910.

256

Case of Traumatic Anosmia.

O. LEVINSTEIN, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 3, 1910.

Man aged 27 years, lost his olfactory sense due to a fall from a wagon, by which he bruised the back of his head but sustained no other injury. The author diagnoses the case as one of traumatic anosmia, and mentions the following possible causes: Injury of the ganglion cells of the gyrus hippocampi; of the cerebral cortex leading to the trigonum olfactorium; of the bulbus olfactorius; or of the lamina cribrosa.

264

Deformity of Nose Following Destruction of Cartilage.

E. MEIERHOF, *Trans. N. Y. Acad. of Med.*, Feb. 23, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1075, Nov., 1910.

266

Foreign Bodies in the Naso-Pharynx.

E. J. MOURE, *Rev. hebdomadaire de Laryngol. d'Otol. et de Rhinol.*, May 7, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 93, Feb., 1911.

269

Primary Tuberculosis of the Nose.

S. OPPENHEIMER, *N. Y. Med. Jour.*, June 11, 1910.

In this case a careful examination fails to reveal any lesion of a tuberculosis other than that found in the nose. The case had been under observation for four years and the obstructing neoplasm in the nose had been frequently operated but the mass always recurred. There was a perforation in the anterior cartilaginous septum about an inch in diameter and in and about this was crowded a mass which completely blocked the nares; the growth was apparently attached to the septum; the septum was enormously thickened.

The growth resembled a papilloma, was very vascular, pale and friable; microscopic section showed giant cells and tubercle bacilli.

The entire tumor, including the cartilaginous septum was completely removed by external radical operation.

There has been no recurrence of the growth in a period of over three years.

GOLDSTEIN.

272

The Relation of the Nose and Accessory Sinuses to Disease of the Eye. (Symposium.)

L. L. PAMER, *Can. Jour. of Med. and Surg.*, Oct., 1910.

The writer reviews the anatomical relations of the sinuses to the eye and cites numbers of cases of infection of the eye from pus in one of these cavities. Personally he is not able to point to one clear case of optic nerve invasion outside of those associated with and due to orbital cellulitis.

WISHART.

278**Case of Cerebrospinal Rhinorrhea with Double Optic Atrophy.**

N. H. PIKE, *Brit. Med. Jour.*, May 7, 1910.

Patient 22 years old. Perfectly healthy until her twelfth year, when she was sick in bed for one year. The chief symptoms were headaches, nausea, drowsiness, convulsions during which she became unconscious. Total blindness developed. Fever during the first days of the illness, but later normal temperature. Since this spell, severe symptoms appeared regularly every three or four weeks, headaches and others of an epileptic nature. For ten months, before the patient came under observation, there had been a constant water exudate from the right nostril while the headaches had decreased in intensity. The interest in this case centers in the fact that at times, there was a reducing substance present in this flow and at times none.

279**Scab-Formation in the Nose. Its Etiology and Prevention.**

W. P. PORCHER, *Jour. A. M. A.*, Aug. 13, 1910.

Abstracted in *THE LARYNGSCOPE*, p. 1001, Oct., 1910.

280**A Case of Syphilitic Thrombosis of the Upper Nasal Retinal Vein.**

PUSCARIN, *Klin. Monatschr. f. Augenh.*, July, 1910.

The author shows in a short review of literature that the cases so far observed chiefly occurred in older persons from fifty to eighty years, from arteriosclerosis, marasmus, senile gangrene, or erysipelas of the face which at first caused orbital thrombophlebitis and then thrombosis of the central retinal vein.—*Ex.*

282**Etiology of Stenosis of the Nose.**

F. REICHERT, *Zahnaertzl. Wchnschr.*, No. 4, 1910.

Reichert calls attention to the various phases of deformity of the maxilla which may cause nasal stenosis and emphasizes the importance of the rhinologist and dentist working hand in hand.

284**Large Foreign Body Four Months in the Rhino-Pharynx of a Child, Two and a Half Years Old.**

ROCHER, *Jour. de Med. de Bordeaux*, Feb. 13, 1910.

In this case the foreign body was a needle. It was successfully removed. Recovery.

290**Early Bacterial Examination of the Secretion from Post-Nasal Region.**

E. C. SCHULTZE, *Med. Rec.*, Dec. 10, 1910.

Numerous observers of late, especially in England, have shown that by the cleansing treatment of nose and throat with a mild antiseptic healthy children could be kept in contact with children ill with scarlatina without contracting the disease. Personally, the author has treated two

families, six children in each family, where one member had contracted scarlatina, and by the simple process of cleaning the nose and throat three times a day for six weeks he has prevented any further spread of the disease.—*Ex.*

298

Lactic Ferment in the Treatment of Ozena.

STEPINSKI, *Arch. Internat. de Laryngol., d'Otol. et Rhinol.*, July-Aug., 1910.

Stepinski used lactic ferment in the treatment of twenty-seven cases of atrophic rhinitis. He thoroughly cleansed the nasal mucosa, applied the galvano-cautery to the turbinals several times and then had the patient use dry ferment at least twice a day. In all the cases the discharge stopped within seventeen to sixty-eight days, while the odor disappeared after the fifth or sixth day. In twenty-two of the patients there was no recurrence.

299

Recent Progress in the Knowledge and Treatment of Diseases of the Upper Respiratory Tract: The Nose and Accessory Nasal Sinuses. H. L. SWAIN.

Original contribution to *THE LARYNGOSCOPE*, p. 771, July, 1910.

302

Total Aplasia of One-Half of Nose.

G. TIEFENTHAL, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 9, 1910.

Mal-formation of right nasal wall which included the sinuses and lacrimal duct. The author is undecided whether atresia in fetal life could have been the etiological cause.

306

Leech in Nasal Fossa.

L. VAQUIER, *Arch. internat. de Laryngol. d'Otol. et de Rhinol.*, Jan.-Feb., 1910.

Girl aged 8 years, swallowed a leech while drinking at a well. After three days the leech became lodged in her nose and from time to time its tail could be seen at the right nasal orifice, but it could not be seized. A speculum-examination revealed a good-size leech adherent to the right turbinate. The nasal mucosa was slightly congested. By means of an alkaline nasal douche the leech was expelled through the naso-pharynx.

308

Diagnosis of Diabetes Mellitus Through Lesions in Nose and Ear.

VIOLET, *Jour. de Med. de Paris*, Sept. 10, 1910.

In one case the nasal mucosa was soft and bled at the slightest irritation. It resembled fungous tissue. In another, there were recurrent throat disorders lasting for long intervals; the tongue was also coated. In one patient there were yellowish tumors on the turbinals and on the septum. All the patients had diabetes.

310

The Bacterial Flora of the Nasal Mucosa in Presence of Rhinitis.

W. WALTER, *Jour. A. M. A.*, Sept. 24, 1910.

Walter describes two years' study of the bacterial flora of the upper respiratory tract, and gives the following conclusions: "The evidence seems indicative that the diphtheroids, particularly *Bacillus segmentosus* of Cautley, are concerned in the production of so-called common cold in its typical manifestations in the nose, and there is much evidence that it occurs in epidemic form. The *Micrococcus catarrhalis* is much more general in its manifestation, and is, probably, also epidemic and productive of a rather more severe inflammation, though mild epidemics occur. It seems likely that the symbiosis of these two organisms increases the virulence. The pneumobacillus of Friedlander is much more concerned in chronic conditions and is probably identical with the ozena bacillus. The pneumococcus of Frankel flourishes in any part of the upper respiratory tract and, when virulent, has been found in pure culture. Clinically, the segmentosus infection is most likely to be in the nose, seldom in the trachea, but may cause otitis media; *Micrococcus catarrhalis* is most apt of all to invade the larynx and trachea, but may occur in the ear or nose and with variable virulence. The pneumobacillus is mostly confined to the nose and sinuses. Influenza is conspicuous by its absence. Pyogenic cocci are non-pathogenic locally, except as secondary invaders, and the probability is that only a limited number of strains are concerned in causation of acute infections on the mucosa, and these are not genuine coryza.—*Ex.*

313

Rare Congenital Deformity of the Nose in an Infant.

G. WILKINSON, *Brit. Jour. of Children's Dis.*, Aug., 1910.

The deformity in Wilkinson's case consisted of a deep depression in the middle line of the nose, with wide separation of the nostrils and flattening and broadening of the whole feature. The nasal bones and nasal processes of the superior maxillae were flattened. There was no separation between the nasal bones. On inspection of the nasal passages the anterior ends of the nasal septum could be seen as a prominent ridge on the inner sides of each vestibule. The two sides of the septum were apparently separated from each other. There was no nasal obstruction. On everting the upper lip there was seen a distinct notch on the buccal surface in the very center of the lip. There was also a well-marked notch in the middle line of the alveolar process. The two halves of the alveolus were not in alignment, but met with a forward-pointing angle. Two uncut incisors could be felt beneath the gum on either side of the mesial notch, showing that this represented a division between the two halves of the premaxillary bone. The deformity arose, no doubt, from failure of fusion of the two mesial masses of the frontonasal process.—*Ex.*

314**Hemophilic Epistaxis.**

A. J. Wood, *Australasian Med. Jour.*, May 20, 1910.

Wood recommends gauze-tamponades soaked in a thyroid gland or thymus tablet solution. To prevent or arrest hemorrhage in hemophilias he used anti-diphtheria serum.

319**Xerosis and Anosmia.**

G. ZICKGRAF, *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzgeb.*, Bd. 3, Heft 1, 1910.

Thirty patients suffering from ozena were examined by the author with Onodi's olfactometer. In half, he found total anosmia and in a third a severe hyposmia. Inhalations of saponin together with the nasal spray produced definite results.

322**Endoscopic Examination of the Naso-pharynx and Larynx.**

H. ZWILLINGER, *Orvosi Hetilap*, No. 17, 1910.

Report on the use of the Hays' pharyngoscope in Budapest.

323**Plugging Nostrils With Cotton as Protection Against Diseases Contagious by Inhalation.**

H. ALBERT, *Jour. A. M. A.*, May 28, 1910.

Infectious diseases may invade the system through the respiratory tract. In fact a person, not himself infected may spread infectious germs carried in his nasal cavity and throat. In epidemics persons residing in different portions of a locality are affected. This is undoubtedly due to the spread of the disease by persons themselves immune who come in contact with those affected.

The author recommends that since cotton is such an excellent bacterial filter it be used in the nostrils of physicians, nurses, and others who come in contact with diseases which spread by inhalation.

326**Bismuth Paste in Chronic Suppurative Diseases of the Nose, Accessory**

• Sinuses, Ears and Mastoid Process.

J. C. BECK.

Original contribution to *THE LARYNGOSCOPE*, p. 1055, Nov., 1910.

328**Results of Operative Treatment of Hay-Fever by Resection of the Anterior Ethmoid Nerve.**

E. BLOS, *Deut. Med. Wchnschr.*, Dec. 8, 1910.

Report of three cases of chronic hay-fever relieved by resection of the nasal nerve as it emerges from the anterior ethmoidal foramen. Details of technic are included.

330

Paraffin Plastic for Nasal Depressions in Children.

BOURAK, *Ann. de Mal. de l'Oreille, du Larynx du Nez et du Pharynx*, June, 1910.

Bourak points out the little recognized frequency of nasal depressions in children and reports nine cases, the youngest of which are a girl of three years and two girls of six years. Only hard paraffin is used, which has a melting point between 43° and 48° C. The paraffin-prosthesis, in spite of the youth of the patients is excellent. None of them suffered inconveniences because of the injection.

331

How Can Epistaxis Be Arrested?

BOURGEOIS, *Progresse Med. Belge*, April, 1910.

Bourgeois in a practical study of the methods for stopping epistaxis says if hemorrhage is not severe, the patient should be seated in a cool place with the head up. He must be relieved of all clothing about the neck which may interfere with the return circulation. The hemorrhage is from the anterior part of the septum. A pledget of absorbent wool should be introduced, not into the orifice of the nostril, but into that of the nasal fossa. The wool should be wet with hot oxygenated water of twelve volumes strength, or in a fifty per cent solution of antipyrin in hot water. By means of the ala a moderate degree of pressure is kept up by the finger. If there is a relapse, examination and rhinological treatment must be instituted as soon as possible after the bleeding. On the anterior part of the quadrangular cartilage are seen one or more small arterial branches in varicose condition; on their track a small brown clot points out the seat of the recent hemorrhage. Some one-tenth solution of cocaine is applied on cotton wool. The clot comes away when the wool is removed, and bleeding must be avoided as much as possible. The bleeding point is then cauterized, and afterwards all varicosities in the course of arterioles. The galvanic cautery to a dull red may be used, or a crystal of chromic acid or of silver nitrate. Chromic acid causes a yellow scab. The patient must not blow his nose, and must introduce twice a day a small quantity of boric vaseline.

In the case of serious hemorrhage, quick and efficient anterior plugging is often necessary. It can be effected by Gariel's balloon as improved by Laurens.

The deflated balloon is covered outside with ointment:—

R Cocaine Hydrochloratis	gr. oj.
Liq. Adrenalin Chloridi	m. iij.
Adipis Lanae Hydrosi	
Paraffini Mollis	ana. dr. 1½
Misce. Fiat unguentum.	

It is then introduced along the floor of the nasal fossa by means of Lubet-Barbon's smooth bladed forceps. It is immediately inflated with pressure enough to hold it in place. At the end of twenty-four hours the air is allowed to escape, and the bag is gently withdrawn.—*Ex.*

332**Treatment of Epistaxis by a Simple Method.**J. BOYD, *Australasian Med. Gaz.*, Jan., 1910.

Boyd describes his method as follows: Take a piece of fine starched muslin from 5 to 6 inches square. Impinge the points of a closed dressing forceps—a thin penholder will do—in the center, and pull the muslin over the forceps, forming a closed umbrella appearance with the forceps forming the handle. This is passed through the nostril until it comes in contact with the posterior naso-pharyngeal wall, when the forceps is withdrawn. The ends of the muslin are now spread over the face and held in place by the fingers of the left hand, and the hollow cone left is rapidly plugged from behind forward with small pieces of cotton wool soaked in any available styptic, *i. e.*, vinegar, as firmly as is thought desirable; the projecting ends of the muslin are trimmed off, and the little operation is completed easily in a couple of minutes. The second nostril is similarly dealt with if necessary. If it be not necessary to plug the post-nasal fossa (doing the latter will almost invariably leave temporary deafness), the muslin cone, after withdrawal of the forceps, can be pulled forward to clear the posterior wall of any pressure before the plugs are introduced. The muslin should not be moistened, and the little plugs should be rapidly introduced before the cone gets flabby with moisture, as they slip in so much more easily.—*Ex.*

336**New Method of Packing the Nostril Designed to Prevent Post-Operative Hemorrhage.**

W. E. CASSELLBERRY.

Original contribution to THE LARYNGOSCOPE, p. 89, Jan., 1910.

341**Esthetic Surgery of the Nose.**J. DAURIAU, *Rev. de Stomatol.*, Sept., 1910.

In an athlete, whose face was deformed by a fracture of the nose, the normal shape was restored without cicatrices. D. resected the septum, removed the nasal obstruction, resected the bone proper, and remodeled the nose and placed it in props to maintain the shape. The operation was performed under chloroform and in the Rose position. The author describes extensively the post-operative technic. The operation is similar to that of Joseph of Berlin.

344**Substitute for Bellocq's Application of Tampon.**V. DWARZAK, *Denver Med. Times and Utah Med. Jour.*, April, 1910.

In difficult cases of epistaxis the author instead of applying Bellocq's method of tamponing the nose, takes a piece of iodoform glue gauze bandage, one inch wide and five inches long and draws through the first two yards a double silk thread, making the stitches long. Then by means of a tamponator the two yards are carried to the posterior pharyngeal wall and the threads drawn tight—thus filling up the posterior

nares. A frontal tamponade is made with the rest of the gauze which lies between the two silk threads. After drawing the threads firmly over the gauze rolls they are firmly knotted.

KELLEY (GOLDSTEIN.)



Iworszak's substitute tampon.

346

Some Features of Nasal Surgery.

J. H. EGBERT, *Yale Med. Jour.*, June, 1910.

In this interesting historical article Egbert says in part:—"Nothing is more rare or striking than a really perfect nose; in no feature is fineness of form more essential to the beauty of the human face. The nose of the Greek sculptors has rendered imperishable the Greek profile. According to the rules of art, the following are the conditions requisite to the beauty of this organ: The nose shall have the same length as the forehead, and present a slight depression at its root or apex. From its apex to its base it should follow a perfectly straight line and come exactly over the center of the upper lip. The bridge, bounded by parallel sides, should widen slightly in the center. The tip should be neither too thin nor too fleshy, and its lower outline neither narrow nor too wide. The lobes must be gracefully defined by a slight depression. Seen sideways, the lower part or base of the nose will have but a third of its total length. The septum should divide the nasal cavities into two equal parts, and the nostrils, rounding anteriorly, arched in the center and tapering posteriorly, should be exactly similar.

"The Abbess Hildegard and her forty nuns, appreciating how highly essential to attractiveness of face the nose really is, delivered themselves from the odious attention of the barbarous Saracens by cutting off this feature. Amputation of the nose was performed by the ancients, particularly in Egypt and India, as the most degrading of punishments.

Sextus Quintus inflicted this punishment upon thieves and scoundrels. Even to the present day the rajahs of the native Indian states persist in the practise. It is scarcely thirty years ago that two hundred and sixty Turkish noses were cut off and sent to Prince Daniel of Celtinge after a battle between the Turks and the Montenegrins.

"In prehistoric times Egyptian priests were wont to repair, renew, and reshape noses that had suffered judicial or other mutilation, but they carried the secret of their method to the dread realms of Isis, whence it has never returned. The Hindus, however, retain their methods to the present day, though they are said to eclipse in antiquity all others, having been practised by certain low caste priests from time immemorial. Indeed plastic surgery is believed to have had its birth in the early efforts of these priests to reconstruct noses. The method of the Hindus, commonly known as the 'Indian' method, is, moreover the most approved method of rhinoplasty in vogue at the present day. It was introduced into Europe in 1813 by British surgeons who, during the early Indian wars, were greatly impressed by the skill exhibited in the repair of noses by these Hindu priests. In this operation, a suitably shaped flap of integument and subcutaneous tissue is released from the forehead, twisted downward, moulded into form and stitched into proper position over the uncovered nasal orifices."

In Italy, noses of wax and of silver were employed to replace the lost member until, in the sixteenth century (1597), one Gassaro Tagliacozzi, an eminent Italian surgeon—professor at Bologna and chief surgeon to the Grand Duke of Tuscany—wrote a book, with numerous illustrations, describing a method employed by himself and certain of his predecessors in the art of making a new nose. This consisted in taking a flap from the patient's arm, which latter was bound immovably to the patient's head by a complicated arrangement of slings and bandages until the flap had grown to the face, when the limb was liberated and the new nose moulded into shape in its new location. As a final step in the operation, a columna was fashioned from the upper lip. This operation, which was known as the "Italian" method, was revived by German surgeons about a century ago as the "German" method (after certain modifications by Graefe of Berlin), and appears to have given rather satisfactory results in the hands of certain operators. It is so tedious and irksome however that it is rarely, if ever, employed at the present day.

The plan of taking a flap from another person was probably not unknown to the Italians, but the popular notion that Tagliacozzi fashioned noses for his patients from the buttocks of persons hired for the purpose, is unfounded, and appears to have originated in the fertile imagination of the author of "Hudibras." In this satire Butler tells how, from a porter, "learned Taliactus

Cut supplemental noses, which
Would last as long as parent breech;
But when the date of knock was out,
Off dropped the sympathetic snout."

Butler's story was derived from one of the yarns of that arch quack and prince of mendacity, Van Helmont, who told how a citizen of Brus-

sels who had lost his nasal appendage, received a new one from Tagliacozzi, obtaining the material from the hyde of a Bolognese porter. About thirteen months afterwards—so runs the tale—as the owner of the new proboscis was walking along the street of Brussels, the newly acquired member suddenly became cold and bloodless, putrefaction rapidly followed and the new nose dropped off. It subsequently came to light, says Van Helmont, that at the moment when the manufactured nose grew cold and began to decay, the porter who had supplied the material for the graft died in Bologna.

In our day, where rhinoplasty has been attempted for the restoration of noses which have been completely lost, the results usually differ widely from the illustrations published in various surgical treatises. Indeed, upon inspecting such a nose a year or more after operation, there will probably be found a flabby, fungus-like appendage whose cosmetic value would be very doubtless were it not that it closes in from view the hideous nasal caverns. For this reason, in such cases, the adaptation of a nose of wood, papier-mache, or similar material, which may be supported on the face by a spectacle frame and kept in position by the adjustment of a light spring placed within the nose, may fitly be considered in lieu of a radical rhinoplastic operation. Where only a portion of the nose has been destroyed or where there is a deformity in size or shape, recourse can be had to a plastic operation, such as swinging into place a flap from contiguous healthy tissues, or the removal of redundancy.

While our present methods of rhinoplasty may be said to differ but little from methods devised and practised centuries ago, the last half century may justly boast of its progress and achievement in the field of intra-nasal surgery; since prior to the year 1858, when Czernak demonstrated the practical use of the rhinoscope, operations through and within the nasal cavities were limited to those possible of accomplishment by the crudest of means. From 1860 to 1880, intra-nasal methods became sufficiently well developed to elevate the field of rhinology to the dignity of a specialty; but the most marked advances have been within the past decade.

Time would fail, to point out the progress in intra-nasal surgery during this period, but attention may be called to the development within this period of ten years, of a single operation, which may be taken as a type. Of all the deformities of the nose with which the rhinologist has to deal, none is more common or more important than deviation and deformity of the septum. The older operations for the correction of septal deformities depended upon the saw, the knife, or the galvano-cautery for removing thickenings, angles, and bulgings from the surface of the septum, sacrificing at the same time the covering mucous membrane. Later, attempts at forcible restoration by crushing, or incising and bending, and subsequent splinting were attempted, but ordinarily resulted in little permanent improvement. It was not until the perfection within the past five years, of the operation of submucous resection of the septum that we possessed an operation based upon sound surgical principles by means of which excellent and lasting results were

obtained. Nor was this perfection attained at a single stride. Its development was through successive stages advanced by eminent rhinologists throughout the world, notable among whom are Killian, Fetterolf, Menzel, Hajek, Jansen, Freer, Mosher, Kyle, Gleason, and last but not least, Ballenger, who gave us the swivel-knife, whereby the method of Menzel and Hajek was made practicable and more easy of accomplishment.

MOSHER.

348

Digitalis in Treatment of Spontaneous Epistaxis.

C. E. FOCKE, *Therapie der Gegenwart*, Sept., 1910.

Focke used digitalis for this in eighty-four cases and it proved successful, except in a hemophilic and in a woman given to excessive coffee drinking and tight lacing. In 75 per cent of the patients, the tendency to nosebleed was promptly and permanently arrested within 24 hours after taking the digitalis, even in a few cases in which the bleeding was due to some anatomic anomaly, correction of which later permanently arrested the tendency to epistaxis. He adds that digitalis formerly was a common remedy for a tendency to hemorrhages but it was abandoned towards the close of the last century for theoretical reasons which have since been shown to be erroneous.—*Ex.*

349

Technic for Total Rhinoplasty.

FORAMITTI, *Deut. Ztschr. f. Chir.*, Bd. 102, 1910.

The author describes minutely the technic he used in a rhinoplasty, performed in a case of luetic total nasal defect.

353

New and Safe Method for Sub-Mucous Removal of Deflected Bony Septum.

O. GLOGAU, *Am. Medicine*, Dec., 1910.

Dr. Glogau uses the identical technic which is now being used in exposing the muco-perichondrium and removes the deviated septum by his horizontal and vertical submucous saws. These saws are used either to indent the cartilage or to saw entirely through, doing away with the breaking or cutting instruments that are now being used in the submucous resection. He pleads for his instruments as being both for the safety of the patient and the efficiency of the operator.

MYERS (GOLDSTEIN).

354

Transplantation of Cartilage in the Correction of Deformities of the Nose.

D. C. GREENE, JR., *Boston Med. and Surg. Jour.*, March 17, 1910.

Two cases of perforation of septum due to abscess. The cartilage from the submucous resection operation on others was used which was absorbed with healing of the perforation.

The transplantation of cartilage without its perichondrium has been shown by the researches of Ollier, Tizzoni, Pruden and others to result in the gradual absorption of the cartilage and its replacement by fibrous

tissue (Marchand, Tizzoni, Ollier, Prudden: *vid Deut. Chir.* 1901, Lieferung, 16-page 451). That cartilage with its perichondrial covering may be successfully transplanted has also been demonstrated. Von Mangoldt (*Chir. Cong. Verhandlung*, 1900, page 463), in three cases of laryngeal stenosis successfully implanted pieces of rib cartilage with perichondrium between the wings of the thyroid cartilage to keep them separated. This surgeon also transplanted rib cartilage successfully in two cases of nasal deformity. Koenig (*Berl. klin. Wochenschr.*, no. 51, 1896), similarly closed defects in the trachea and cricoid ring by pieces of cartilage taken from the thyroid cartilage. Goodale (*Boston Med. and Surg. Jour.*, July 25, 1901 and *Ann. of Otol. Rhinol. and Laryngol.*, Nov., 1900), has also reported cases of successful transplantation of septal cartilage in the same individual for the correction of nasal deformity.

The little work Greene adds which I have done in this direction was prompted by the material at hand due to the present prevalent operation of submucous resection of the septum. If it is possible to transplant cartilage from one individual to another, the large flat pieces which we frequently obtain in the submucous operation would seem to be ideal for use in cases of nasal deformity in which the cartilaginous septum has been destroyed. If the cartilage were entirely absorbed, at least no harm would result from the procedure.

In the two cases which I wish to report this evening the deformity was the result of an undrained abscess of the septum with almost complete destruction of the quadrangular cartilage. The problem was the replacement of the lost cartilage by cartilage freshly removed by submucous resection from the septum of another individual.

A vertical incision is made in one nostril on the septum just posterior to the muco-cutaneous junction, as in the usual submucous operation. Through this incision the two layers of mucous membrane which form the anterior part of the septum are separated by dissection. This dissection is much more difficult than in the submucous operation where the cartilaginous septum is present. A sharp tenotome used with great care to avoid perforation is necessary. The two layers of membranous septum having been thus separated in the region in front of the incision as well as behind, the chamber for the reception of the cartilage is ready. A piece of cartilage which has been freshly removed from the septum of another case, washed and placed in sterile normal salt solution, is now trimmed with scissors into the required shape and placed in the chamber. The wound is then closed at its upper part by one or two catgut sutures, and both nostrils are lightly packed. In both of the cases in which this operation was done there was slight reaction, and the wound healed readily, as after the submucous operation.

The first patient, a boy of seven years, was operated upon two years ago. The improvement in his profile is noticeable, as shown in the photographs taken just before the operation and two years after. This alteration in the contour exists in spite of the fact that the cartilage has, in the interval since operation been apparently absorbed, since it cannot be felt.

The second case, a girl of eight, was operated upon two months ago. In her case the cartilage has not been absorbed and can be distinctly

felt on pressing with the finger over the anterior part of the bridge of the nose. These two cases appear to demonstrate that cartilage may be transplanted in cases of destruction of the cartilaginous septum. Although it does not grow in the new locality, and becomes eventually absorbed, it has at least in children the value of preventing an increase in the deformity which if left untreated, becomes more marked with age.

MOSHER.

355

Direct Endoscopy of the Naso-Pharynx and the Eustachian Tube and the Posterior Region of the Naso-Pharynx.

A. VON GYERGYAL, *Ann. des Mal. de l'Oreille du Larynx du Nez et du Pharynx*, April, 1910, and *Orvosi Hetilap*, No. 9, 1910.

Patient, placed with head hanging low, is examined with a Bruenings' electroscope by means of which the accessory sinuses may be seen and intervention made on them. The inferior wall of the maxillary sinus may be opened and in this way the hypophysis may be reached. All other nasopharyngeal operations may also be performed.

359

Treatment of Nasal Synechia by Dilatation with Rubber.

KAUFMANN, *Rev. Hebd. de Laryngol. d'Otol. et de Rhinol.*, May 21, 1910.

After dissecting out the synechia, the author inserts drainage rubber tubes which are changed daily. He claims good results from this method. He states that he has also had good results from this method in stenosis of the external auricular canal.

SCHEPPEGRELL.

362

New Operative Procedure to Relieve Synechia in the Nose.

O. KOERNER, *Ztschr. f. Ohrenh. u. f. Krank. der Luftw.*, Bd. 60, p. 252, 1910.

The technic consists in separating the synechia and removing that portion of the septum to which the cicatricial tissue was attached to prevent re-union. The method is simple and effective except in children with congenital syphilitic cicatrices.

368

Improved Technic for Paraffin Treatment of Ozena.

R. LEROUX, *Presse Med.*, May 7, 1910.

Though Leroux agrees with Zarniko's theory as to the etiology of ozena, he also holds that abnormal width of the nasal cavity may be a cause. Microbes cause the odor. Leroux has obtained good results with paraffin treatment, using the Gault injection, slightly modified and hard paraffin with a melting point of forty-five degrees C. A few days after the injection he treats the nose with hot air so as to melt the paraffin and thus gain the advantages of the Moure-Brindel soft paraffin technic, while escaping the disadvantages.

370**New Operation for the Relief of the Various Obstructions of the Anterior Nares.**

J. E. MACKENTY, *Trans. N. Y. Acad. of Med.*, May 26, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 116, Feb., 1911.

371**Procedure in Nasal Hemostasis.**

MARCHAL, *Arch. Med., Belge*, June, 1910.

Review of the different means of stopping epistaxis, from the simple Gallen tamponade to the modern procedures.

372**Treatment of Fracture of the Nose and Deviation of the Nasal Septum.**

C. AND F. MARTIN, *Lyon chir.*, Jan., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 594, May, 1910.

378**Original Method for Prevention of Perforation in Sub-Mucous Resection.**

R. M. NELSON, *Jour. A. M. A.*, Nov. 29, 1910.

The Doctor by accident discovers an original method for prevention of perforation in the submucous resection. He had noticed that on several occasions, when he had made button-holes in the mucous membrane, he did not get a perforation. In looking for an explanation he noticed that where these button-holes were not made opposite to each other perforation did not occur.

In one of his following operations he incised the muco-perichondrium down to the cartilage; his next step was to go posterior one-eighth to one-quarter of an inch before cutting the cartilage, in order to engage it with a swivel knife. This gives, as he terms it, a natural splint for his mucous incision and does away with the chance of a perforation.

MYERS (GOLDSTEIN).

379**Intra-nasal Opening of the Cranial Cavity and of the Brain.**

A. ONODI, *Orvosi Hetilap*, No. 12, 1910.

This article will appear as a monograph in both German and English.

381**Present Status of Vaccine Therapy in Diseases of the Nose and Ear.**

J. A. PATTERSON.

Original contribution to *THE LARYNGOSCOPE*, Sept., 1910.

382**Note on the Use of Bismuth-Gauze in Rhinology and in Otology.**

E. PISTRE, *Rév. hebdomadaire de Laryngol., d'Otol. and Rhinol.*, April 2, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 850, Aug., 1910.

383**Plastic of the Tip of the Nose From the Upper Lip.**E. A. POLYA, *Orvosi Hetilap*, No. 1, 1910.

After operation for nasal epithelioma a defect extending to the upper border of the apertura pyriformis remained, upon which this plastic operation was performed. The cosmetic result was good.

387**Suggestions for the Operative Correction of Syphilitic and Other Deformities of the Nose.**JOHN B. ROBERTS, *Ann. of Surg.*, Feb., 1910

This article is chiefly a discussion of the various flap and transplantation operations for the cosmetic relief of deformities of the nose. It is copiously illustrated with cuts demonstrating various operative procedures, and the results obtained by some of the author's cases. PACKARD.

389**Immunization Treatment of Hay-Fever.**SCHEFFEGRELL, *Rev. hebdom. de Laryngol. d'Otol. et de Rhinol.*, Feb. 5, 1910.

Abstracted in THE LARYNGOSCOPE, March, 1909, page 311.

392**Utilization of Conjunctiva from Eye in Plastic Restoration of Nasal Passages.**O. SPRENGEL, *Zentralbl. f. Chir.*, June 11, 1910.

The author details the technic by which a defect on the bridge of the nose caused by the removal of a carcinoma was thus effaced.

394**Modified Simpson's Tampon to prevent Nasal Hemorrhage.**M. D. STEVENSON, *Jour. A. M. A.*, June 4, 1910.

Abstracted in THE LARYNGOSCOPE, p. 848, Aug., 1910.

395**The Treatment of Lupus Cari Nasi. Communication from Finsen's Institution.**O. STRANDBERG, *Dan. Klinik.*, p. 1369, 1910.

At Finsen's institution oxydol is used and not ozone in the treatment of Lupus cari nasi. The patient received three grams Na.I. daily, divided into small portions. At the same time a tampon was applied to the inside of the nose twice daily, and several times an hour he moistened it thoroughly with two per cent H_2O_2 .

Thirteen patients with this disease were treated. Ten had a positive Wassermann; test not made is three. In nine of the thirteen complete recovery; in three improvement and in one no result because the patient did not follow the treatment. The duration of the treatment was in one instance five days, in three, two or three weeks, in two, four weeks, in two eight weeks and in one three months. The duration is not proportionate to the extension of the disease.

KIAER.

397**Conservation of the Mucous Membrane in Intranasal Surgery.**H. C. TODD, *Med. Herald*, April, 1910.Abstracted in *THE LARYNGOSCOPE*, p. 996, Oct., 1910.**399****Treatment of Nasal Fractures.**J. TREMOLIERES, *Ann. des Mal. de l'Oreille, du Larynx du Nez et du Pharynx*, Oct., 1910.

T. emphasizes the value of simplified methods for reduction of nasal fracture, describes the technic of Escat and employs a Volkmann or Tripler dilator to lever the fractured nasal bones into position. The spoon or dilator is covered with a rubber nipple to prevent unnecessary bruising. He advocates as little nasal packing or splints as possible using sheets of dental gutta percha moulded to proper shape and size as an external splint.

GOLDSTEIN.

402**Transplantation for Nasal Synechia and for Adhesion of the Velum Palati to the Posterior Pharyngeal Wall.**VON EICKEN, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61, Heft 2, 1910.

In Liebenmann's clinic transplantation is satisfactorily employed for synechia in the nose and adhesion of the velum palati to the posterior pharyngeal wall. After that if the sub-mucous operation for the resection of the septum be performed the synechia is divided and a contractria inserted between the surfaces of the wound. The Kuppen lobe must be twice as long as the tampon and as wide as its circumference. After three to six days the tampon is softened with hydrogen peroxide and carefully removed from the nose. In the site of the former synechia the gauze usually sticks, but upon removal a new skin quickly forms. The danger of the flattened epithelium of the epidermal lobe leading to epithelial disquamation and crust-formations is hardly potent.

404**Cosmetic and Therapeutic Application of Paraffin in Rhinology.**M. WASSERMANN, *Muench. Med. Wchnschr.*, May 17, 1910.

Wassermann gives illustrations of the fine results of injection of cold paraffin to correct saddle nose, the patients having been under observation for nine years. In thirty other cases he applied the injection in the treatment of ozena. In ten of these cases two years have passed and the excellent results have persisted. This method of treatment of ozena by injection of paraffin under the mucosa is indicated only when the mucosa is comparatively stout; if extremely atrophied it is unable to retain the paraffin.—*Ex.*

405**Rhinoplasty by Means of One of the Fingers.**S. H. WATTS, *Ann. of Surg.*, Feb., 1910.

The patient was a man whose face had been torn away by a load of shot fired at close range. The finger was held to the face by a plaster

cast until amputated. The result as shown by photographs taken before and after the operation was excellent. PACKARD.

409

Experiences with Rhino-plasty.

N. WOLKOWITSCH, *Arch. f. klin. Chir.*, Bd. 93, No. 3, 1910.

Wolkowitsch reports a number of rhino-plastic operations; in two of them he made the new nose out of the patient's fourth finger, as he describes in detail. The first case dates from 1896. His experience, he thinks, encourages further work in this line, as also with the Italian method of rhino-plasty which was applied in the other cases.—*Ex.*

411

Case of Congenital Cyst of the Soft Palate.

E. BERGH, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Vol. 44, March, 1910.

In an infant, boy, aged seven months, suffering from dyspnea, restless sleep accompanied with snoring and cough, a white body was detected behind the soft palate. Under ether a pedunculated tumor the size of an almond was removed from the posterior aspect of the uvula. Microscopic examination showed it to be a cyst such as occur at embryological "lines of closure." Only two other such cases are recorded.

416

Carcinoma of the Palate.

DIONISIO, *Gaz. degli Osped.*, Feb. 13, 1910, and *Gaz. med. ital.*, June 23, 1910.

Case in which radium and Roentgen rays were ineffective. Dionisio, however, by means of radiations—which he had already successfully used in ozena and otitis media—effected a cure. The radiations, which are not specified, are of definite wave-lengths.

420

Lipoma of the Velum Palati.

H. GAUDIER, *Presse Oto-Laryngol. Belge*, Jan., 1910.

On the occasion of a case which came under the author's observation and was operated by him, he discourses on this variety of tumor and alludes to the few recorded cases.

421

Case of Papilloma of the Anterior Right Pillar of the Velum Palati.

B. DE GORSSE, *Arch. internat. de Laryngol. d'Otol. et de Rhinol.*, March-April, 1910.

The author published this case after reading that they were of such rare occurrence. Since then he has been convinced of their frequency.

422

Disturbances in Motor Function and Reflex Excitability in Palate, Throat and Larynx of Hemiplegics.

GRAEFFNER, *Berl. klin. Wchnschr.*, Jan. 10, 1910.

The author draws these conclusions from observations on two hundred cases: In hemiplegics one often finds apparent motor disturbances

in the soft palate seldom in the larynx; these disturbances are usually on the paralyzed side. Isolated paralysis of the contra-lateral vocal cord is the reflex result of a bulbar and not a cerebral affection, unless extra-cerebral complications be present. Tremor of the vocal cords are less frequently curable after apoplexy than with tabes and multiple sclerosis. The irregularity of the changeability of the position of the uvula in hemiplegics—as well as in some perfectly healthy people—is no evidence of apoplexy. The hypo-reflex of the palate, pharynx and larynx is also a useful symptom.

423

Observations on the Palate, Pharynx and Larynx in Cerebral Hemiplegia.

GRAEFFNER, *Berl. klin. Wchnchr.*, No. 2, 1910, and *Ztschr. f. Laryngol. Rhinol. u. ihre Grenzgeb.*, Bd. 2, Heft 5, 1910.

In hemiplegics we find frequently, apparent motor disturbances in the soft-palate, less frequently in the larynx. Repeated attacks predispose to this condition. The motor disturbances are most frequently, but not always, on the affected side. Isolated paralysis of the contra-lateral vocal cord depends, when no extra-cerebral complications are present, on a bulbar affection rather than on a cerebral lesion. Tremor of the vocal cord and ataxia are less frequent following apoplexy than in tabes or in multiple sclerosis. Irregularity or change of position of the uvula in hemiplegics and also the relative frequency of this condition in normal persons admits of no diagnostic conclusions in apoplectics. There is, however, some justification for this conclusion in the tent-like contraction of the soft palate, irrespective to which side it may be drawn. Reflex or absence of reflex of the palate, pharynx and larynx are also serviceable symptoms.

SAMSON (KUTTNER)

424

Endothelioma of the Velum Palati; Pre-auricular Endothelioma.

GRATIA, *Clinique*, Feb. 12, 1910.

One tumor was on the velum palati of a 20-year-old girl, the second on a woman aged 24 years. The youth of the patients, the slow development of the swelling, its benignancy, the absence of pain, gland-metastasis and recurrence contra-indicate cancer.

425

Exposure of the Base of the Skull by a Temporary Resection of the Palate.

C. HOFMANN, *Zentrbl. f. Chir.*, June 11, 1910.

Hoffmann says that up to the present time the exposure of the base of the skull through the palate has been the least developed of the operations to expose the base of the skull, and that it has been done only by a median splitting of the soft palate and a more or less extensive resection of the hard palate. To gain a freer exposure Hofmann did the following operation: An incision is made through the mucous membrane transversely from the right premolar across the palate to the left premolar and down to the bone. At right angles to this incision another is made along the alveolar process to the palatopharyngeal arch. The direc-

tion of the incision may be reversed according to the site of the tumor to be removed. Over the hard palate the incision passes to the bone and through the whole thickness of the soft palate. The hard palate in the line of the incision is chiselled through, and by means of a periosteal elevator this osteo-plastic flap is easily turned to one side. The nasal septum either breaks or can be cut through. The tumor at the base of the skull in Hofmann's case was thus exposed almost in its whole extent and was easily removed. The replacing of the flap was likewise easily accomplished. Two sutures in the transverse and two in the longitudinal portion of the incision sufficed to fix the flap in place. The hemorrhage was naturally slight owing to a preliminary ligation of the external carotid. Hofmann thinks it would still be slight in the absence of such ligation.—*Ex.*

429

Cleft Palate Operations.

T. S. KIRK, *Brit. Med. Jour.*, Dec. 31, 1910.

Kirk has used a continuous suture (No. 1 or 2 silkworm gut) in cleft palate operations with satisfactory results during the last three years. The operation he performs is the ordinary one with mucoperiosteal flaps in the case of the hard palate, and in the soft palate the latter is freed from the posterior margin of the bony palate and its muscles are divided. Apart from the ultimate good results obtained, he says that it will be found that this continuous suture can be inserted more rapidly and easily than the interrupted one, and that the necessity for great care to insert the stitches exactly opposite each other and to tie the sutures with the correct amount of tension is obviated. The ease and rapidity of operation makes the operation less serious, and it can easily be done when the child is 18 months old. The amount of tension to be put on this suture must be sufficient, after it has been put in and before it is finally tied, to prevent the escape of any bubbles from the nose to the mouth in any part of the line of suture, when the patient is breathing quietly. The suture is put in close to the edges of the flap, only taking up enough to invert the margins. The suturing is most easily done from before backward. The form of needle Kirk uses is a small Durham's cleft-palate needle, bent at a right angle to the right, and he inserts it from below on the right side and from above on the left side, usually rethreading before each introduction. Only about one-half inch of the silkworm gut should be passed through the eye of the needle, as the gut is apt to get frayed by the constant threading and unthreading. The suture can be left in for ten days or longer. He claims for a continuous suture that it gets rid of two of the causes of failure of union in cleft palate operations, namely, (1) imperfect apposition of the flap edges; (2) necrosis of the flap edges from stitch pressure; and that it considerably shortens the operation, thus materially diminishing the risk.—*Ex.*

432

Diagnostic Importance of Ulcerations on the Palate in Typhoid.

M. LUEDIN, *Corresp. Bl. f. Schweizer Aerzte*, Aug. 20, 1910.

The general symptoms and the development of a typical ulceration on one side of the palate in the two cases reported suggested typhoid

fever, but the further course of the disturbances contradicted this assumption. Both patients were tuberculous but the ulceration had no features characteristic of a tuberculous lesion. In the experiences at the Basel medical clinic these ulcerations of the palate were observed in eleven and seventy-six one hundredths per cent of the sixty-eight cases of typhoid in the last three years, but the two cases reported show that they are not pathognomonic of typhoid.—*Ex.*

434

A Peculiar Tumor of the Palate.

R. W. MARSDEN and C. P. WHITE, *Med. Chron.*, April, 1910.

The patient was a woman of 37 years, who had noticed for a period of ten months a swelling on the roof of the mouth. On the left side of the hard palate at the level of the first molar was found a tense cystic tumor covered with unaltered mucous membrane, and about the size of a hazel-nut. The mass was easily shelled out under cocaine anesthesia. Microscopically it consisted of a connective tissue matrix embedded in which were numerous tubes dilated here and there into cystic spaces. For the most part these were lined with a single layer of squamous epithelial cells with a layer external to them of columnar cells. In a few of the tubes, however, the innermost layer consisted of cubical cells, and in others it was replaced by several layers resembling stratified epithelium. Within the tubes in some parts were masses of short prismatic colorless crystals of a peculiar nature, possibly akin to Charcot's crystals. The nature of the tumor is discussed and the authors conclude, mainly on account of the diversity and in some places transitional character of the cells lining the tubes and spaces, that the growth has originated from "indifferent cells." In that case it should be regarded as similar to the "parotid tumors" and classed with them among the blastocytomata.

GUTHRIE.

435

Case of Hemiparesis of the Velum Palati.

A. PUGNAT, *Rev. Hebd. de Laryngol. d'Otol. et de Rhinol.*, Aug. 27, 1910.

Patient 33 years old. Chronic tonsillitis. During the use of the galvano-cautery the patient suddenly experienced an acute pain and in crying out showed that she snuffed. Examination of palate revealed paralysis of whole right side. Pognat thinks that the galvano-cautery touched the pharyngeal nerve.

436

Surgical Management of Complicated Harelip and Cleft Palate.

J. B. ROBERTS, *N. Y. Med. Jour.*, Jan. 1, 1910.

Immediately after birth the mother should press the two halves of the upper jaw together firmly with her fingers two or three dozen times a day. This orthopedic procedure tends to lessen the width of the fissure. As soon after birth as possible, the soft and semi-cartilaginous bones of the upper jaw should be forced together by means of a Hammond clamp or by the more formal operation of Brophy, with wire tie beams and lead plates. About the same time that this replacement of

the bones is attempted, the alveolus should be reconstructed in front, if there be any great deviation in the alignment. Any protrusion of the intermaxillary bone must next be corrected by a plastic or osteoplastic operation at the front part of the septum of the nose. Any gap remaining in the roof of the mouth must next be closed by a flap operation. A fissure in the upper lip must be closed by carefully applied sutures and the deformity of the nostril must be corrected. If the lower lip is conspicuously prominent a V-shaped piece must be excised and perhaps the upper lip widened by insertion of tissue from cheek, chin, or hand.—*Ex.*

437

Edema of the Palate.

L. S. SOMERS, *Jour. A. M. A.*, Sept. 10, 1910.

The occasional seriousness of edema of the soft palate in spite of its apparently trivial appearance as a symptom, is pointed out by Somers. A simple local uvulitis has no serious significance except that edema of any portion of the upper air passages may extend itself to the larynx with all the seriousness that that implies. Acute uvulitis, however, is not infrequently associated with general conditions like rheumatism or influenza, or with local conditions like peritonsillar abscess, and in some cases the palate may bear the brunt of the inflammation. It also may occur from direct traumatism and some people seem to be especially vulnerable in this part, edema of the palate occurring frequently from various causes. It is sometimes a prodromal symptom of rheumatism or gout and may be found preceding lumbago, sciatica, etc. The arthritic diathesis seems sometimes to play an important role in producing edema of the palate. In severe types of faucitis, like erysipelas or septic infection, uvular edema is almost always an accompaniment and of serious import. In chronic specific infections it may occur, as in tuberculosis and syphilis, and be significant of destructive local lesions with grave general debility. It is a suspicious symptom or an indication of kidney disease and the danger of laryngeal involvement is always present, and in angioneurotic edema the swelling of the palate may be enormous and require active treatment at once. It may precede urticaria or accompany it. Swallowing of corrosive substances may also be a cause and it may be a symptom of certain drugs like cocaine or scopolamin. Edema of the tip of the uvula is not uncommon and causes little concern. Hawking or vomiting or nocturnal mouth breathing may produce it. The symptoms vary from slight tickling to suffocation, and great annoyance is frequently caused because of the feeling of necessity of clearing the throat and constant hawking. The recumbent posture aggravates the symptoms and the patient may not be able to lie down for fear of suffocation.—*Ex.*

445

Advantages Inconveniences and Dangers of Removing Faucial Tonsils.

J. BROECKAERT, *Presse Oto-Laryngol.*, March, 1910; *Bull. de la Soc. belge, d'Otol. etc.*, Part 1, 1910, and *Arch. internat de Laryngol., d'Otol. et de Rhinol.*, Sept.-Oct. and Nov.-Dec., 1910.

The author first considers the advantages of removing these "portals of infection" and mentions several disorders of which faucial lesions are

the direct or indirect cause. He then points out the disadvantages of removing an organ which serves also as a protection and whose real function is not clearly known. He shows in what respect tonsillotomy is dangerous and what preventative measures must be taken to avoid complications.

449

The Spirocheta Pallida. Its Relation to the Tonsil.

R. P. CAMPBELL, *Jour. A. M. A.*, May 14, 1910.

The author treats of the method of examining the tonsil, of the findings in normal and pathological conditions and concludes that in about eighty or ninety per cent. of patients suffering from untreated secondary syphilis, forty-four out of the series of forty-nine cases, the spirocheta pallida may be found in tonsil serum.

450

Some Practical Points in the Total Extirpation of the Tonsils from the Experience of 500 Cases.

W. B. CHAMBERLIN.

Original contribution to THE LARYNGOSCOPE, p. 903, Sept., 1910.

451

Routine Use of Ligature in Tonsillar Bleeding with Description of Technic.

L. COHEN.

Original contribution to THE LARYNGOSCOPE, p. 893, Sept., 1910.

453

Results of Treatment of Peri-Tonsillar Abscess by Dilatation of the Sub-Tonsillar Fossa by Killian's Method.

P. M. CONSTANTIN, *Rev. hebdomadaire de Laryngologie, d'Otologie et de Rhinologie*, July 30, 1910.

Coolidge holds that colds never start from chill, exposure, etc., but Report of one hundred and sixty cases of tonsillar abscess treated by Escat within the last fourteen years. Sixty-two were operated by Killian's method. Out of twelve of his own cases, Constantin operated ten by Killian's method and obtained absolutely successful results.

455

Relation of Inflammation of the Tonsils to Infectious Diseases.

H. CURSCHMANN, *Muench. med. Wchnschr.*, Feb. 8, 1910.

Cryptogenic sepsis may result from small tonsillar abscesses. Nephritis and articular rheumatism with chronic endocarditis may result from a simple tonsillitis, or from a purulent tonsillar thrombosis. Some cases of polyarthritis may also be traced to tonsillar origin. Of course the best test of the relation of these various disease to those of the tonsil is the relief that can be obtained in the former by curing the latter.

457

Experimental Study of Bacteria Isolated from Tonsils.

D. J. DAVIS, *Jour. A. M. A.*, July 2, 1910.

Report of the examination of the tonsils for their bacterial flora in forty-five patients, surface cultures often being taken before removal and surface and deep cryptal cultures after removal. The excised tonsils were at once placed in a sterile receptacle and taken to the laboratory where smears and blood-agar plate cultures were made first from the surface. The tonsil was then incised with a hot sterile knife, thus exposing the crypts and from these similar smears and cultures were made. In many cases anerobic cultures were also made. In almost every case a pure growth or a nearly pure growth of *Streptococcus pyogenes* was obtained from the crypts. This was true regardless of the clinical condition of the patient. From the surface of the tonsils the flora, as a rule, was strikingly different from that in the crypts. The predominating organisms on the surface belong to the pneumococcus group, all producing green colonies on blood-agar and some, but not all, being inulin fermenters. In many cases streptococci were also present on the surface but they were relatively few even when the crypts contained them in large numbers. In some cases examination of swabs taken from the surface of the tonsils just before tonsillectomy gave results similar to those obtained afterward. Not infrequently pneumococcus-like colonies were obtained from the depths of the tonsils in considerable numbers, but as a rule the number was in more or less direct proportion to the tissue laceration and contamination of the depths of the tonsil by surface organisms.

Anerobic cultures gave, as a rule, few organisms and none of the varieties found occurred with any degree of constancy or appeared to be significant. In two cases a practically pure growth of *Staphylococcus albus* was obtained from the crypts. In most cases staphylococci were not present at all, or only an occasional colony occurred on the plates. Occasionally long thread-like bacilli were seen in smears; these were not cultivable. In one case of recurrent tonsillitis, the last attack being four weeks previous to the tonsillectomy, cultures from the crypts gave a nearly pure growth of the diphtheria bacillus, while cultures from the surface of the tonsils taken both before and after excision did not reveal this organism. There is good reason to believe that an outbreak of several cases of diphtheria occurring at this time in persons closely associated with this patient, may be thus explained. This case, therefore, is an example of a diphtheria-carrier in which the bacilli were present in the tonsillar crypts and were not revealed by the ordinary method of examination. All strains of streptococci were tested on dextrose, lactose, mannite, raffinose and inulin. All fermented dextrose and none fermented raffinose and inulin. A large number of the strains fermented lactose and a smaller number fermented mannite. They may therefore be divided into well-defined groups with reference to mannite and lactose fermentation. This grouping bears no evident relation to the clinical condition. Similar groups are observed in strains of streptococci isolated from other sources, which is in accord with the findings of others.—*Ex.*

458**Severe Sepsis Following Tonsil Operations.**

L. W. DEAN.

Original contribution to *THE LARYNGOSCOPE*, p. 739, July, 1910.**459****Calculus of the Tonsil.**DUPOND, *Gaz. hebdomadaire des Sci. med. de Bordeaux*, May 8, 1910.

Patient presented paresthetic symptoms in the posterior pharynx—the sensation of a foreign body, difficulty in swallowing the saliva. Examination of the throat showed, on the upper pole of the left tonsil partly hidden by the anterior pillar, a small white mass. Opening the crypt with the galvano-cautery revealed a calculus, the size of a small pea, hard, round, shriveled of black color. It had appeared white before, due to the caseous matter with which it was covered.

460**Bacteriological Examination of Tonsillar Crypts at the Manhattan Eye, Ear and Throat Hospital, New York, During Winter 1909-1910.**

J. G. DWYER AND GIGNOUX.

Original contribution to *THE LARYNGOSCOPE*, p. 1042, Nov., 1910.**463****Indiscriminate Enucleation of the Tonsil.**P. FRIDENBERG, *N. Y. Med. Jour.*, Jan. 1, 1910.

Fridenberg warns against the reckless removal of the tonsil in toto. If removal be necessary, for instance, if the respiration be interfered with, he favors finger enucleation. In cases of submerged adherent or cryptic tonsils where inflammation is an operative indication, he admits the need for interference, but he points out how little is really known about the tonsil and that care must be exercised.

465**Suture of the Faucial Pillars for Hemorrhage Following Tonsillectomy.**R. H. GILPATRICK, *Boston Med. and Surg. Jour.*, July 21, 1910.

Gilpatrick says that suture of faucial pillars for haemorrhage following tonsillectomy has usually to be done without anaesthesia, and the condition of the patient is often such that none is needed. The choice of position in which the patient is best put rests on the individual operator and the circumstances. He uses the Rose position with satisfaction. Good light is of course necessary. In the Rose position the patient's head is but little elevated above the chest, which point is worth considering in a nearly exsanguinated patient. At the same time, less blood and mucus are likely to be inhaled. The jaws must be opened to their full extent, and the tongue kept on the floor of the mouth. This is best done with the Whitehead self retaining gag with attached tongue depressor. A small, round pointed, fishhook shaped needle is threaded with black linen or silk. The thread should be about eighteen inches in length. A long shanked Mayo needle holder has proved adaptable. When the suture is ready to be placed, the pharynx is quickly wiped out and an ordinary

right angled metal tongue depressor introduced so that its tip presses against the base of the tongue just at the lowest point of the faucial pillars and away from the side being operated upon. This gives a view of the point at which the first bite of the needle should be made. The point of the needle is carried behind the lowest portion of the posterior pillar and is introduced forward through both pillars, taking enough tissue to insure its not tearing out. The needle is pulled through, leaving the tail of the suture sufficiently long to reach beyond the incisors where it is twisted with the main portion of the suture between the thumb and forefinger. A perforated shot is now slipped over the needle and tail of the suture and the shot grasped in the jaws of the needle holder. One hand holds the twisted suture taut while the other, grasping the needle holder, forces the shot against the point of suture of the pillars and crushes it upon the thread. The tail of the suture is now forced between two convenient teeth and the suture continued as a running, over and over, to the other end of the pillars. The bites should be about a quarter of an inch apart and should include sufficient tissue to prevent tearing out. The tail of the suture has been left long, the suture drawn tight, and the head and tail of the suture twisted together as before. Another perforated shot is slipped over the needle, grasped in the holder, forced against the point of suture of the pillars, and crushed. If the ends of the suture are left permanently long and secured to the teeth, it will do away with the possibility of the shot dropping into the larynx in case the suture should break or tear out.—*Ex.*

470

Peri-Tonsillar Abscess with Description of New Instrument for Opening and Irrigating the Abscess.

H. HAYS, *Am. Medicine*, Dec., 1910.

Dr. Hays in an admirable article explains how peri-tonsillar abscesses are formed and the best way for their surgical treatment. He cites that in the case which has not advanced far containing the parts and applying a solution of 50 per cent silver nitrate in the supra-tonsillar fossa, will frequently abort the condition.

If it is necessary to use the knife he uses an incision which starts just a trifle external to the anterior pillar, making the diagonal cross the uvula. The only addition to our previous methods in treating with these conditions is the use of a rather long pointed forceps, which he inserts into the incision with an irrigating trocar attached to the lower blade; he spreads the blade of the forceps and attaches a tube through which some strong antiseptic solution is allowed to flow. He claims that he is not entirely original in this idea, but owes some credit to Doctors St. Clair Thomson and Black.

MYERS (GOLDSTEIN.)

472

The Anatomy of the Capsule of the Tonsil and Its Significance in the Treatment of Diseases of the Tonsil.

G. S. HETT, *Jour. of Laryngol., Rhinol. and Otol.*, Nov., 1910.

In this article the author considers from a practical surgical standpoint the anatomical connections of the capsule, the blood supply of the

tonsils and its relation to the capsule, the relation of the lymphatics to the capsule the process by which secretions are discharged from the crypts, the capsule in relation to tonsillar inflammation in tuberculosis, in malignant tumors, and its role in the removal of tonsils.

The author's anatomical studies seem to lead him to the opinion that in all cases in which the tonsils need to be removed at all, the capsule should be included. The embedded tonsil of early childhood is usually removed because of cervical adenitis rather than on account of sore throat. In such cases if a portion of the tonsil is left it may still continue to act as a source of infection. In case of small, tough tonsils with adherent pillars, in which removal is determined upon not because of size, but because of sepsis, and constant recurring sore throat, a complete operation is equally indicated.

When the tonsil has been removed by the guillotine the capsule is cut through and some tonsil is generally left behind, no matter how skillfully it may be done. Hemorrhage too is more likely to occur, and the subsequent occurrence of quinsies is not prevented.

To ensure complete removal, the essential is the primary separation of the pillars, so that the capsule can be defined and readily separated and so removed entire with the contained tonsil by any of the various methods in vogue.

WELLS.

482

The Truth About Tonsils and Adenoids.

J. W. JERVEY, *Jour. A. M. A.*, May 14, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 902, Sept., 1910.

485

Removal of the Faucial Tonsil Followed by Basedow's Disease.

C. J. KOENIG, *N. Y. Med. Jour.*, Dec. 24, 1910.

Attention is called to the causal relation between the removal of the tonsil and symptoms of Basedow's disease, and various suggestions are offered for its pathogenesis and pathology.

GOLDSTEIN.

487

When and How Should Tonsils Be Removed?

LANCE, Gaz. des Hop., March 29, 31 and April 2, 1910.

The author prefers tonsillotomy in that it is more radical, less dangerous and less apt to give rise to profuse hemorrhage.

489

Differential Diagnosis of Syphilitic Chancre of Tonsil and Chancriform Angina.

A. LE PLAY and A. SEZARY, *Presse Med.*, July 27, 1910.

Le Play and Sezary report a case in which the chancre developed in the left tonsil, the lesion presenting the aspect of an ulceromembranous sore throat. The persistence of the lesion for three weeks notwithstanding systematic gargling with potassium chlorate was suspicious although there was no enlargement of glands in the vicinity and the ultramicroscope revealed spirochetes. The diagnosis of syphilis

was confirmed by a roseola that developed soon afterward and the positive Wassermann reaction. There was no fever at any time. In a second apparently similar case there was slight fever towards night and a slight tendency to glandular enlargement, but the ultramicroscope revealed the spirilla and fusiform bacilli of Vincent's angina and the course of the case confirmed this diagnosis. In both cases the microscopic field contained two or more specimens of the spirocheta refringens.—*Ex.*

490

• The Question of the Function of the Tonsils.

O. LEVINSTEIN, *Arch. f. Laryngol. u. Rhinol.*, Vol. 23, Heft 1, 1910.

The author critically reviews the various theories of the function of the tonsils, especially the Brieger-Goerke, which regards the tonsils as a protection against infection. But this theory cannot be proved histologically, experimentally nor clinically.

492

• Thirty-Five Cases of Tonsillitis With Sepsis.

L. LIEBL, *Med. Klinik*, Jan. 9, 1910.

Minute description of two of the thirty-two cases, in which the symptoms were very severe—one ended fatally. In both cases the center of infection was in the naso-pharynx from which profuse greenish-yellowish foul-smelling pus issued.

493

Acute Nephritis Following Acute Tonsillitis.

H. W. LOEB, *Jour. A. M. A.*, Nov. 12, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 64, Jan., 1911.

495

Tonsillectomy With Special Reference to Recent Points in Technic.

O. A. LOTHROP, *Boston Med. and Surg. Jour.*, June 2, 1910.

Lothrop describes the method of tonsillectomy used by him, which operation is followed by less hemorrhage than the other methods. If bleeding occurs, press a pledget of gauze on a holder into the tonsillar sinus for at least three minutes. If this does not suffice, the anterior pillar may be retracted and perhaps a bleeding point may be caught with a long hemostat. If these attempts are unsuccessful, the pillars may be sutured together over a pledget of gauze. This should check any ordinary hemorrhage. As a last resort a tonsil clamp may be applied. Astringent applications and adrenalin are not efficient in the presence of much blood, and are not reliable. They render the tissues more susceptible to infection and secondary hemorrhage. The surgeon should see that all hemorrhage has ceased before leaving the patient. Because of the liability to hemorrhage, tonsillectomy is more safely done in a hospital.—*Ex.*

496

Acute Nephritis Following Severe Tonsillitis.O. MARSHALL, *Va. Med. Semi-Monthly*, March 25, 1910.

Report of a case of severe tonsillitis with acute nephritis and marked albuminuria for several weeks, coming on after convalescence from tonsil affection.

GOLDSTEIN.

498

The Responsibility of the Tonsil in Tuberculous Adenitis.FRANK S. MATHEWS, *Ann. of Surg.*, Dec., 1910.

The author opens with a statement as to the wide divergence of views as to the responsibility of the tonsil for the condition of tuberculosis of the cervical lymph glands. The writer submits the results of the examination of sixty-five whole tonsils recently removed. He divides them into three groups: (1) Fifty-seven tonsils removed for a variety of reasons from children, and embracing all types of tonsils. In none of these patients was there reason to suspect tuberculosis in the neck or other parts of the body. No evidence of tuberculosis was found in any of the tonsils. This is in accord with the experience of others and he believes justifies the assertion that the tonsil is not likely to harbor tuberculosis unless it is manifest in some other part of the body. (2) Five tonsils showing well-defined tubercular lesions and all taken from children with recent tuberculous cervical adenitis. (3) Three cases with tuberculous glands in the neck, but without tuberculosis in tonsil.

Dr. Mathews agrees with Hurd that tuberculosis does not enlarge the tonsil. The lesion found in the tonsil is generally the early or cellular type, not the late fibrous and necrotic. We should recognize more the frequency of tonsillar infection and remove the tonsils early in cases of cervical adenitis. That we have been able to cure so large a per cent of our cases of glandular tuberculosis without removing the tonsils is an illustration of the fact that we do not cure tuberculosis by removing every single bacillus and lesion, but by reducing the blood of infection with which the body must contend. If the tonsils and nodes are both removed, it should not be done at one operation. Which shall be done first depends on the individual case. We have seen the nodes largely subside on the removal of the tonsils alone; in other cases the extensive involvement of such nodes makes their removal much more important than that of the tonsil.

PACKARD.

501

Hemorrhage After Tonsillotomy.A. MEYER, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, May-June, 1910.

Complete account of the frequency, the course, the etiology and the treatment of post-operative hemorrhage. The maxillaris externa, the lingualis, the pharyngea ascendens, the palatina ascendens and the tonsillar arteries are the most frequent sources of hemorrhage.

503

Tonsil Operations and Speech Disturbances.

NADOLECZNY, *Muench. Med. Wchnschr.*, Jan. 18, 1910.

The author states that tonsillectomy is sometimes contra-indicated; for it may aggravate an already existing speech defect, as in cases of congenital or acquired palatal defect. In these cases the tonsil contributes towards narrowing the space between the palate and posterior pharyngeal wall. Several cases are cited.

504

Case of Sarcoma of the Tonsils Treated with the Roentgen Rays.

NOWICKI, *Tygodnik Lekarski*, No. 25, 1910.

Large sarcoma of the tonsil of long standing, in man aged 45 years, decreased rapidly under Roentgen ray treatment. At autopsy necrosis of the sarcomatous infiltration especially on the nasal side wall of the soft palate.

505

Fatality Following the Removal of Tonsils and an Adenoid Growth.

F. R. PACKARD, *Am. Jour. of Med. Sci.*, Sept., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 44, Jan., 1911.

512

Primary Sarcoma of the Palatine Tonsils.

S. PUSATERI, *Arch. Ital. di Otol., Rinol. e Laringol.*, July, 1910.

Histological study of a primary lymph-sarcoma of the palatine tonsil which spread to the muscles of the neck and to the vault of the pharynx.

519

Tonsillectomy.

B. R. SHURLY, *Jour. A. M. A.*, Oct. 29, 1910.

The difficulties and contraindications of tonsillectomy are discussed by Shurly, who gives the history of the radical operation, finding that, except perhaps in Scotland, it seems to be out of favor with European operators. The function of the tonsil is not yet definitely settled but it is permissible to believe with Bordley that these glands in early infancy act as governors over the system of ductless glands and possess an internal secretion from the normal tissue which regulates various ratios of polymorphonuclear and mononuclear blood cells. Tonsillectomy is contra-indicated in advanced cases of tuberculosis and he thinks it a mistake to make it a rule that because a patient has had tonsillitis twice in one year the tonsils must come out. Tonsils that have been involved in recent acute inflammations should not be operated on until the acute condition has subsided and many tonsils seen by the general practitioner with every appearance of pathologic condition never give rise to local systemic symptoms. He advises the use of ether as a general anesthetic in this operation in children and it should be a hospital operation when possible.—*Ex.*

527

Nature of Peri-tonsillar Abscess in Pulmonary Tuberculosis.

D. TANTURRI, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, March-April, 1910.

In a case of peri-tonsillar abscess observed by Tanturri there were only slight reactionary symptoms and the cervical glands were indolent. Since the patient had a tubercular infection, Tanturri concluded that this was an unusual case of peri-tonsillar abscess. The pus showed the presence of sebum-like bacilli. The abscess was punctured but recovery was long delayed. The author feels that he has here found an analogy to the well-known tubercular retro-pharyngeal abscess.

529

Report of a Fatal Case of Quinsy in an Adult.

J. J. THOMSON.

Original contribution to *THE LARYNGOSCOPE*, p. 1124, Dec., 1910.

530

Neuralgias and Functional Disturbances Arising from Infections in and about the Tonsils.

F. C. TODD, *Jour. A. M. A.*, Aug. 27, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1015, Oct., 1910.

532

Gangrene of Neck and Face of Tonsillar Origin.

VAN DEN WILDENBERG, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, July-Aug., 1910.

The author describes a case of very rapidly developing gangrene which extended deeply into the pharynx, attacking all the periphery of the parotid gland. It extended under the skin to the right naris, to the sub-maxillary and sub-lingual glands, stopping at the median line. The gangrenous region comprised that part of the face, limited above by the zygomatic arch, posteriorly by the ear and the inferior-posterior border of the lower jaw, anteriorly by a line from the external angle of the eye to the inferior border of the maxilla. Cellular tissues, muscles, glandular and periglandular tissues were involved. The most gangrenous region was the parotid gland and the sub-maxillary gland. The infection was produced by a phlegmonous angina. Radical operative procedures were employed.

The gangrenous tissues were removed at great depth. Fortunately the facial nerve was spared. Frequent dressings and syringing were resorted to and the interstices kept as wide open as possible. Fifteen days after the operation from behind the parotid a long gangrenous fragment or shred was removed, after which recovery ensued.

GOLDSTEIN.

537

Carcinoma of the Uvula.

Er. M. HOLMES, *Ann. of Otol. Rhinol. and Laryngol.*, Sept., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 71, Jan., 1911.

553**Accessory Thyroid of the Tongue.**

T. J. HARRIS, *Trans. N. Y. Acad. of Med.*, Oct. 26, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 128, Feb., 1911.

554**Hairy or Black Tongue.**

M. L. HEIDINGSFELD, *Jour. A. M. A.*, Dec. 17, 1910.

The literature of hairy or black tongue is reviewed by M. L. Heidingsfeld, who divides his subject into two general classes: (1) true, idiopathic, or genuine cases, characterized by well-defined, stable, black-brown or yellow-brown thick, soft, fur-like patches covered with densely intertwined hair-like filaments; and (2) false, pseudo, or spurious cases characterized by thickish yellow-brown or greenish discolorations of evanescent character, covered with a soft mushy detritus occasionally containing short filaments shorter than in the other form. The true cases originate in some developmental anomaly, developing from germinal products present at birth, but showing themselves in early adolescence or later. The pseudo cases probably owe their origin to general or local irritation or disease and are not uncommon in the early stages of syphilis. A parasitic nature has not been demonstrated.—*Ex.*

558**Circumscribed Lymph-angioma of the Tongue.**

C. MANTELLI, *Arch. ital. di Otol. Rinol. e Laringol.*, Feb., 1910.

The author reviews the cases published and adds his personal observations gained by a histological examination.

LASAGNA.

560**Foreign Body in the Tongue.**

W. MURRAY, *Brit. Med. Jour.*, Jan. 1, 1910.

In this case the foreign body was a piece of the handle of a pipe one cm. long. It was knocked into the tongue by a blow and remained in the tongue for seven months before its removal.

562**Fibroma of the Tongue.**

PETGES, *Gaz. Hebd. des Sci. Med. de Bordeaux*, April 24, 1910.

Fibroma of the tongue in woman aged 35 years. A diagnosis could not be made. The tumor was removed with difficulty and a microscopical examination revealed a fibroma.

565**Case of Tic of the Tongue.**

C. S. POTTE, *Med. Rec.*, Jan. 22, 1910.

Cutaneous disease, twenty years ago in region of mouth. To relieve this irritation he used to stick out his tongue, which soon became a habit. Now at times, the patient cannot restrain himself from opening his mouth and sticking out his tongue as far as possible.

567

Sarcoma of the Tongue.

G. SERAFINI, *Riforma Med.*, April 11, 1910.

Serafini collected the cases of lingual sarcoma recorded in literature. In 1897 Morior published a complete collection of cases, twenty-four in number, reported up to that year. Since then nine additional cases have been reported, making, with the present case, a total roll of thirty-four cases on record. The patient, whose history is recorded here, was a woman, 34 years of age. At the age of 12 she had accidentally wedged a splinter into her tongue, which her physician had been unable to remove completely, and it was at the site of the foreign body that a small tumor developed which afterward proved to be a sarcoma. The patient made a perfect recovery after the removal of the tumor.—*Ex.*

572

Neurofibromatosis of the Tongue in a Child.

F. P. WEBER, *Brit. Jour. of Children's Dis.*, Jan., 1910.

The patient, a rather delicate-looking boy, aged 6 years, had a hard swelling below the tongue, which, according to the mother, had been almost certainly observed when the child was ten months old. The tumor in question formed an oval projection on the under surface of the tongue, situated along the right side of, and parallel to, the frenum linguae, about half way between the tip of the tongue and the orifices of Wharton's ducts. The surface of the projecting tumor, which was apparently covered by healthy mucous membrane, was partly whitish and partly reddish in color. No evidence of disease in the thoracic or abdominal viscera could be detected, and the general health of the boy appeared satisfactory in spite of his somewhat delicate appearance. The projecting portion of the tumor was removed, and on examination showed bundles of medullated nerve fibers bound together by a close connective-tissue stroma. Weber regards the tumor as being neurofibromatous, and a hard cord still remains to the right of the boy's frenum linguae, doubtless representing part of the lingual branch of the fifth cranial nerve.—*Ex.*

574

Diseases of Bucco-Noso-Pharyngeal Origin Simulating Pulmonary Affections.

H. ABOULKER, *Ann. de Mal. de l'Oreille du Larynx du Nez et du Pharynx*, Feb., 1910.

Coughs of long duration, asthma, and hemoptysis are traceable to affections of the nose and throat. Several cases are reported in which after removal of nasal polypi or uvula wrongly diagnosed diseases of long duration have disappeared. Such patients have often been treated for pulmonary tuberculosis, especially patients suffering from hemoptysis. Very often the source of this bleeding is the nose, the nasal cavity, or even the gums.

575**Relation Between Diseases of the Mouth and Systemic Diseases.**

H. B. ALLYN, *Pa. Med. Jour.*, Feb., 1910.

Allyn believes that diseases of the gums and teeth are of great interest: (1) because they show manifest local disease with absorbent surfaces from which pathogenic bacteria may be carried to produce systemic disease, or local disease elsewhere; (2) because the diseases of the gums and teeth may be mere local expressions of systemic diseases. Carious teeth, gingivitis and stomatitis not only lead to malnutrition but produce a foul mouth, from which are absorbed poisons which cause a variety of local and general disturbances. On the other hand, dentists especially have discovered that it is sometimes impossible to arrest erosion and to cure gingivitis until a toxic state of the tissues is recognized and removed. The lesson to be learned is that the mouth must be carefully inspected both for the prevention of disease and for the diagnosis and cure of obscure metabolic disorders.—*Ex.*

578**Tuberculosis of the Lip.**

G. E. ARMSTRONG, *Ann. of Surg.*, April, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 97, Feb., 1911.

579**Vincent's Angina.**

H. ARROWSMITH, *Ann. of Otol. Rhinol. and Laryngol.*, Sept., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1092, Nov., 1910.

594**Case of Metastatic Appendicitis and Cholecystitis in Puerperium with Remarks on Septic Infection Through the Mouth.**

B. BOSS and E. FABRICUS, *W. klin. Rundschau*, Nos. 38 and 39, 1910.

Four weeks before parturition acute empyema of the left maxillary antrum with several carious teeth and pulpitis. At time of labor only slight symptoms remained. After six weeks sudden attack of appendicitis and cholecystitis. The author is of the opinion that the etiology of the disease was hematogenous or due to the intestinal miscarriage of the oral infection.

595**Mycosis Leptothrica of the Pharynx.**

BRELET, *Gaz. des hop.*, March 10, 1910.

Author describes the well-known symptoms. The fungus grows only in developed cases chiefly in those affected with tuberculosis. Treatment consists in removal of fungus and cauterization with a solution of iodide and iodide of potassium, iron-chloride or zinc chlorid.

596**Large Dermoid Cyst on the Floor of the Mouth.**

J. BROECKAERT, *Presse Oto-Laryngol.*, Jan., 1910.

Tumor was easily removed in spite of its being attached to the hyoid bone. In spite of the size of the tumor, the operation was performed

through the mouth, for esthetic reasons; for by the sub-hyoid passages cicatrices would have been left.

599

Bacteriology of the Stomatitis of Pellagra.

W. H. BUHLIG, *Qr. Bull. N. W. U. Med. School*, Dec., 1910.

Out of the fourteen cases examined twelve showed a combination of spindle-shaped bacilli and long wavy spirochetes, from which the author concludes that these organisms are one of the factors in stomatitis. In cultures on Loeffler's serum many Gram-negative organisms were found which from their size and irregular staining with methylene blue suggested colon bacilli. By carrying the cultures through various media two Gram-negative organisms were secured, one much like the bacillus lactis urogenes and the other like the bacillus cloacae.

600

Different Reports of Two Pneumo-gastric Nerves in the Cervical Region.

A. CACHET, *These de Paris*, 1910.

In fifty per cent of the cases, the vagus nerve on the left side is situated at least during a part of its cervical course anterior to a frontal plane passing through the axis of the carotid. This condition is usual on the right side. When anterior to the carotid, the pneumo-gastric nerve generally describes, on its antero-external side a curve whose most convex part is always adherent to the corresponding thyroid lobe. This should be remembered in operations on the cervical region and especially on the thyroid.

603

Case of Pharyngo-Laryngeal Sporotrichosis.

A. CAPART, *Presse Oto-Laryngol, Belge*, No. 9, 1910.

Man, aged 70 years, suffering from severe dysphagia, had at the base of his tongue a hard, ulcerated tumor which secreted profusely and simulated a malignant tumor. Thanks, however, to multiple cicatricial sporotricha-lesions the diagnosis was rectified and potassium iodide, three grains per day, caused a rapid disappearance of the pharyngeal lesions.

605

Retro-Pharyngeal Abscess.

E. W. CARPENTER.

Original contribution to THE LARYNGOSCOPE, p. 563, May, 1910.

612

Remarks on Vincent's Angina, with Report of Cases.

G. CHAMBERS and H. WILSON, *Dom. Med. Monthly*, March, 1910.

The necrotic area is never thick and fibrinous, and in the cases seen an areola of a dull red hue suggested a considerable degree of stasis of blood.

The author thinks it probably that cancrum oris should be placed in the same category as Vincent's angina. The spirillum while varying considerably in length and number of spirals is invariably larger than

the spirochaeta pallida. The organisms of Vincent's angina and diphtheria are never found together, while syphilis may be coexistent. Three cases are recorded.

WISHART.

619

Pharyngeal Branch of the Sub-Maxillary Ganglions in Man.

CUTORE, *Riv. ital. di Neuropath.*, Aug., 1910.

From ten autopsies on adults, Cutore concludes: A network of nerves runs from the posterior plane of the submaxillary ganglion to the palato-glossus, where it branches. From thence it can be traced to the superior pharyngeal muscle. It pierces this muscle and penetrates into the pterygo-pharyngeal fossa. From thence it disperses upwards into the base of the skull.

621

Case of Vincent's Angina.

DEBINSKI, *Medycyna*, No. 12, 1910.

In a patient affected with laryngeal tuberculosis, a greyish-white area appeared on the right tonsil with partial necrosis, containing typical fusiform bacilli. No fever. The urine, however, showed traces of albumen.

624

Study of Ludwig's Angina.

DELIE, *Rev. hebdomadaire de Laryngol. d'Otol. et de Rhinol.*, July 16, 1910.

As symptoms Delie mentions the following: Rapid swelling of the sublingual fold; hard swelling of the floor of the mouth through which absolutely no fluctuation can be felt; no pathological decoloration of the skin of the neck elevated through the swelling. Of course later the skin becomes anemic and necrotic. In addition the general condition is septic. The treatment of course is only surgical.

625

Retro-Pharyngeal Abscess.

E. DELNEUVILLE, *Presse Oto-Laryngol. Belge*, April, 1910.

Report of a thorough study of retro-pharyngeal abscesses. D. divides them into three groups: Cold abscess, ganglionic tubercular abscess and abscess through congestion (Pott's disease). He treats the anatomy of the region of the symptomatology of the affection, which varies according to its etiology, of differential diagnosis with phlegmonous tonsillitis, and of croup (in children), and indicates their respective treatments.

629

Tumors of the Parotids.

DUPOND, *Gaz. hebdomadaire des Sci. med. de Bordeaux*, April 17, 1910 and *Jour. de Med. de Bordeaux*, Feb. 20, 1910.

Presentation of a tumor of both parotids which formed appreciable swelling. The swelling appeared first at a crisis, but decreased later. It has remained since the twelve crisis, seven years ago.

631**Grippal Pharyngodynia or a Painful Form of Grippal Angina.**

E. ESCAT, *Rev. hebd. de Laryngol. d'Otol. et de Rhinol.*, Dec. 17, 1910.

Escat reports twenty-seven cases of this peculiar manifestation of grippé, all the cases showing a striking contrast between the intensity of the symptoms and the local lesion.

These cases were characterized by a vesicular eruption of the velum palati, the small translucent elevations resembling grains of sago.

SCHEPPEGRELL.

643**Vincent's Angina During Quarantine for Diphtheria.**

F. FRALEY, *Jour. A. M. A.*, May 7, 1910.

The interesting features of the epidemic were: the mildness of the cases, the spread of the infection through an intermediate party and the fact that the characteristic bacilli was found in the mouths of several children whose gums were spongy and bled easily, but no ulcer formed, nor did any exudate take place.

644**Recurrent Parotid Enlargement.**

S. A. FRIEDBERG, *Trans. Chicago L. and O. Soc.*, March 22, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1167, Dec., 1911.

649**Case of Benignant Glosso-Mycosis.**

GAUTZ, *Medycyna*, No. 26, 1910.

Rare case of lingual mycosis of which the author finds no mention in literature. Woman aged 30 years, complained for several weeks of dysphagia and considerable salivary excretion. A white area, a millimeter thick, was apparent on the right side, closely attached to the tongue. It was removed with difficulty. The other respiratory organs were apparently normal. No fever. Microscopic examination: Typical lepto- and Gram-negative fungus growth.

654**Pharyngo-Temporal Fibroma.**

GORIS, *Presse Oto-Laryngol. Belge*, April, 1910.

Case of fibroma originating from the pterygoid basilar periosteum, passing from the pterygoid maxillary fissure and opening into the temporozygomatic fossa. The hard pedicle occupied the lateral part of the upper pharynx. Preventive tracheotomy. Removal with sub-periosteal resection of the upper maxilla. Uranoplasty. Recovery.

656**Rupture of the Vessels of the Neck into the Pharynx in Scarlet Fever.**

J. H. GRIFFITHS, *Glasgow med. Jour.*, Jan., 1910.

Report of two cases of scarlet fever in which death was almost instantaneous and in which autopsy showed rupture of the artery of the neck.

657

Pathology of the Cranio-Pharyngeal Canal.

W. HABERFELD, *Frankfurt. Ztschr. f. Pathol.*, Bd. 4, Heft 1, 1910.

Examination of six cranli of new-borns revealed an entirely continuous cranio-pharyngeal canal. It lies in the median plane. Its course runs posteriorly upward then forward and diagonally downward. Its superior orifice borders on the sella turcica, its inferior on the roof of the sphenoid bone.

658

Treatment of Acute Inflammation of the Pharyngeal Walls and Tonsils.

H. HALASZ, *Aertzl. Vierteljahrs-Rundschau*, No. 1, 1910.

In such inflammations Halasz uses at first a strong solution of iodine and glycerine; later on a weaker solution. He also employs this to pencil the lateral and posterior wall of the pharynx in acute inflammation of the tonsils.

671

Oral Prophylaxis.

A. IRWIN, *Jour. A. M. A.*, Feb. 12, 1910.

Oral prophylaxis is the art of preventing disease, deformity, and injury to the mouth by means of manipulation, instrumentation, and skillful surgical treatment. Practical application of oral prophylaxis (prevention by surgical instrumentation) should be made in behalf of public school children. The consent and active co-operation of the school authorities is the most essential consideration now to secure the introduction of oral prophylaxis into the public schools by dentists. The practical application of oral prophylaxis is a problem in economics, because it is the most effective means of combating the spread of contagious disease from oral infection among the public. The solution of the problem lies in the establishment of free dental school clinics for the introduction of oral prophylaxis by dentists.—*Ex.*

683

Chronic Pemphigus of the Mucosa.

LANNOIS and CURTIL, *Ann. de Mal. de l'Oreille, du Larynx du Nez et du Pharynx*, March, 1910.

Cases of pemphigus of the conjunctiva, the nose, pharynx and larynx in man aged 69 years. It began five years previous with pemphigus of the pharynx. Two years later characteristic pemphigus blisters appeared on the conjunctiva. Pemphigus signs appear in the nose in the form of crusts and in the larynx in ulcerations of the epiglottis and arytenoid cartilage. As usual in the early stages of pemphigus of the mucosa the rest of the body is free.

684

Case of Scurvy.

E. LANZURICA, *Rev. Ibero-Am. de Sci. Med.*, April, 1910.

Detailed report of a case of scurvy with the usual symptoms—lesions of gums and mucous membrane of mouth, capillary hemorrhage in the cerebral cortex, etc.—in puerperium. The suffering was intense. Recovery through hygienic and dietary measures.

689**Prognosis of Palato-Laryngeal Hemiplegias.**

F. LEMAITRE and M. SIMONIN, *Ann. de Mal. de l'Oreille du Larynx du Nez et du Pharynx*, March, 1910.

In the majority of these cases the prognosis is unfavorable because of their etiology. There are, however, three cases recorded in French literature where recovery was complete and the author adds two more which were cured under antisyphilitic treatment.

694**Pseudomeningococci in the Throats of Healthy Children.**

LIEBERKNECKT, *Arch. of Hygiene*, Vol. 68, p. 443, 1910.

In eight per cent of fifteen school children examined, pseudomeningococci were found. None of these children had been exposed to meningitis. With one exception none of these organisms could be distinguished by cultural methods from the real meningococcus. This one gave a yellow growth on potato. At a temperature of fifty-five degrees and after twenty-four hours they were agglutinated by specific serum in high dilution while the serum of a normal rabbit had no effect. On saccharine media these growths cannot be distinguished from the real. They grow well in pure culture on placental agar and in blood serum. On the addition of hematin to normal agar they grow abundantly and retain their vitality for a month. The addition of the saccharate of iron to ordinary or placental agar improves the growth on these media satisfactory at either room or blood temperature.—*Ex.*

697**Neurotic Mucous Ulcer of Mouth; Chronic Aphtha.**

LOERLOWITZ, *Arch. f. Dermatol.*, Bd. 102, 1910.

This disease was observed in the members of a large family and was more pronounced in the females. The author holds that the ulcers neuroticum is a neurotic mucous gangrene similar to Kreibich's neurotic cutaneous gangrene.

706**Contribution to the Knowledge of Congenital Pharyngeal Cysts.**

MARANGONI, *Gaz. degli Osped.*, March 1, 1910.

Tumor of interest because of its size—equal to that of an orange—and its relation to the vessels and nerves of the neck. It belongs to the group of amygdaloid cysts which are composed of lymph-follicles.

707**Syphilis and Tumors of the Pharynx of Malignant Nature.**

F. MASSEI, *Bull. de Laryngol., Otol. et Rhinol.*, April 1, 1910, and *Arch. ital. di Laringol.*, Bd. 29, Heft 1, 1910.

Report of eight cases in which syphilis developed into cancer. Massei regards syphilis as a local trauma which favors the formation of a tumor which would otherwise probably not have formed.

713**Acute Retro-Pharyngeal Abscess in Children.**

MENIER, *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzgeb.*, Bd. 3, Heft 1, 1910.

The author reports on five cases observed by him during the winter. He describes the symptoms and recommends operative treatment—the child in a sitting position. He describes accurately his technic.

719**Two Cases of Pharyngeal Fistula.**

MOINET and BERGERET, *Ann. Med Chir. du Centre*, Feb. 27, 1910.

In the first case the phlegmon was in the lateral region of the neck above the sterno-mastoid muscle. It was opened and disappeared. This was a case of recurring phlegmon which the author explains as the result of an internal one-eyed fistula in the pharynx. The second case—also one of a soldier—was operated for a tumor the size of a nut and of ganglionic appearance, situated in the median super-hyoidean region. After the operation there were symptoms of pharyngeal fistula.

720**Pigmentation of Buccal Mucosa in Pernicious Anemia.**

T. G. MOORHEAD, *Brit. Med. Jour.*, April 9, 1910.

Moorhead adds one case to the four cases previously reported by others in which there was well-marked pigmentation of the mucous membrane of the mouth in pernicious anemia.—*Ex.*

721**Pharyngo-Cutaneous Fistula.**

MORESTIN, *Bull. de la Soc. de Chir.*, May 3, 1910.

Patient aged 27 years. Fistula of neck at the left anterior border of the sterno-cleido-mastoid muscle. For fourteen years abscesses had been forming at the site. Operation. Cure.

722**Operation for Parotid Fistula.**

R. D. MOTHERSOLE, *Practitioner*, Feb., 1910.

Man aged 60 years, operated for sarcoma of the right cheek at a level with the parotid. Recurrence of the growth necessitated a second operation, whereby a fistula of Stenson's duct formed. The author minutely describes the plastic operation whereby this condition was relieved.

736**A Case of Advanced Phthisis of the Pharynx and Larynx.**

PFANNENSTILL, *Hygieia*, p. 472, 492, 1910.

Report of further cases of phthisis and lupus in the upper air passages treated with NaI and O₂, and an account of the modification and the practical use of the methods.

An antiseptic in the nascent state has a specially strong increased mortal power on bacteria. The ideal is gained when this creation takes place in the diseased tissue. Pfannenstill is of the opinion that this is reached

by giving NaI per os and mixing the air from inspiration with ozone. On the diseased spot there will be formed after the formula, $2 \text{ NaI} + \text{O}_3 + \text{H}_2\text{O} = 2 \text{ NaOH} + \text{O}_2 + 2 \text{ I}$. In addition the free iodine acts upon NaOH after the formula $\text{NaOH} + 2 \text{ I} = \text{NaI} + \text{NaOI} + \text{H}_2\text{O}$; $6 \text{ NaOH} + \text{O}_3 + \text{I}_2 = \text{NaIO}_3 + 5 \text{ NaI} + 3 \text{ H}_2\text{O}$.

NaI is formed again and again and separated into free iodine continuously by the conducted ozone. The direct application of the NaI on the mucous membrane is of no use. Ozone alone is without effect.

Pfannenstill has treated four cases; the first was a 25-year-old woman with pulmonary, pharyngeal phthisis. The pharynx, rhino-pharynx and hypo-pharynx was the seat of a connected ulcerative action, which had completely destroyed the whole of the soft palate. The process had attacked the larynx with great ulcerations on the epiglottis and plica arytenoidea. Wassermann positive. She was treated energetically in the common hospital and Finsen's institution, with KI and unguentum hydrargyri without result; on the contrary the ulcerations spread. After one month's treatment with NaI and ozone she recovered, with formation of great scars.

Girl, aged 14 years, with lupus nasi; Wassermann positive; KI without effect, but NaI and ozone brought about a cure in one month.

Man, aged 40 years, with phthisis pulmonalis et laryngis; Wassermann positive; the ulcerations healed during one month.

Girl, aged 13 years, with lupus nasi; three weeks' treatment; recovery.

In one case with lupus vulgaris on the shin he used ozone, instead of oxydol (H_2O_2) after the formula $2 \text{ NaI OH} + \text{I}$. KIAER.

739

Caseous Paradental Cyst.

E. PISTRE, *Rev. hebdomadaire de Laryngol., d'Otol. et de Rhinol.*, Nov.-Dec., 1910.

Caseification is a sequel affecting cysts, infecting them from a suppurating focus. It is produced by coagulated diastase, the product of various bacteria and especially by the aspergillus moulds. Neither locality nor the diatheses contribute to its production. Exploratory puncture may be a source of error in diagnosis. The treatment of caseous paradental cysts does not vary from that of ordinary cysts. This monograph carefully discusses the pathogenesis of caseous para-dental cysts.

GOLDSTEIN.

746

Lipoma of the Lip.

PRINCETEAU, *Gaz. Hebdomadaire de Bordeaux*, July 10, 1910.

Lipoma of upper lip which greatly annoyed the patient. Removal. Healing by primary intention. Formation due to labial glands.

752

Malignant Tumors of the Throat Arising from Syphilitic Cicatrices with Report of Four Cases.

C. ROBERTSON, *Jour. of Ophthalm. and Oto-Laryngol.*, Nov., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1178, Dec., 1910.

753

Palato-pharyngeal Adhesions.

J. O. ROE, *Jour. A. M. A.*, Jan. 15, 1910.

In discussing palato-pharyngeal adhesions and the methods adopted for their relief, Roe describes a new operation which he devised for the relief of a case of practically complete occlusion in a woman, aged 24 years, whose condition was the result of a traumatism which had been produced in attempting to excise the tonsils one year previously. Practically, the operation consists in separating the parts and covering the raw surfaces with plastic flaps taken from the sound sides of the palate and passed from before backward. For details the reader must be referred to the original.—*Ex.*

754

Vincent's Angina.

J. D. ROLLESTON, *Brit. Jour. of Children's Dis.*, July, 1910.

Vincent's angina may be defined as a faucial lesion usually unilateral in distribution and characterized by a deep ulceration of the tonsil and adjacent structures. There is often a peculiar fetor given off and children have been brought to hospital on account of this fetor and ulceration of the tonsil. The present paper is based on an observation of thirty-two cases. The disease is uncommon compared to other forms of sore throat. It occurs almost exclusively in children and it is very feebly contagious. The organisms found are a fusiform bacillus together with a spirillum which was described by Vincent for the first time in 1896. There is always a great disproportion between the local and the general symptoms, in fact the latter are often very slight indeed. Compared with diphtheria the throat takes a much longer time to clear up in Vincent's angina. There are no complications and the mortality is very low. The treatment consists in swabbing the throat with tincture of iodine.—*Ex.*

760

Unusual Case of Buccal Oospore.

A. SARTORY, *Arch. internat. de Laryngol. d'Otol. et de Rhinol.*, May-June, 1910.

As a contribution to the role of the oospore in pathology, the author publishes his fourth case of buccal oospore.

761

Physiology of Deglutition.

SCHIEER, *Trans. Berl. Laryngol. Soc.*, May 5, 1910.

Roentgenography of deglutition by means of one to three grains of bismuth carbonate or diaphanite. Examination of two phases: 1. Formation of the bolus in the mouth. 2. Descent of the bolus into the esophagus. The epiglottis does not serve to close the entrance to the larynx as heretofore supposed, at least it does not perform this function alone (unaided) since without the epiglottis or with a defective epiglottis the patient can swallow very well. SAMSON (KUTTNER).

769**Recent Progress in Knowledge and Treatment of Upper Respiratory Tract: The Oro-and Naso-Pharynx.****W. K. SIMPSON.**

Original contribution to THE LARYNGOSCOPE, p. 783, Aug., 1910.

775**Radical Extirpation of Pharyngo-Esophageal Pressure Diverticula.****STETTEN, Ann. of Surg., March, 1910.**

Report of a case of a man 65 years old, successfully treated. Stetten also reports on sixty cases, whose histories he has collected, of which fifty recovered, ten dying.

778**Retro-pharyngeal Abscess Consequent to External Otitis in a Child.****TANTURRI, Gaz. internat. di Med., Feb. 6, 1910.**

Tanturri emphasizes the importance of examining the pharynx in otitis. In his case the abscess was clearly consequent to the otitis. The author prefers operation through the oral passages since this procedure does away with the narcosis and the painful dissection of the carotid region.

786**Vincent-Plant-Angina and Syphilis.****S. VERNON, Arch. ital. di Otol. Rinol. e Laringol., Feb., 1910.**

The author presents a case of supposed cancer of the larynx in an old man, aged 73 years, who presented the characteristics of ulcerated lues. Examination did not reveal the existence of a luetic infection. It was, however, ascertained that the pathogenic agents were the spirilla and the fusiform Vincent's bacilli.

LASAGNA.

788**Multiple Sarcoma of the Pharynx.****W. VOGELSANG, Ztschr. f. Ohrenh. u. f. Krank. der Luftw., Bd. 61, Heft 3-4, 1910.**

Case 1. Mason, 23 years old; history negative. On the posterior right wall of the uvula and soft palate and partially embracing the left tonsil an irregular ulcer. Removal. Recovery.

Case 2. Man aged 27, also with negative history. Lues negative. A short time ago his breathing became difficult and a physician removed "polyp." Ulcers on posterior pharynx and on palate. The tumors were removed but they grew so rapidly that patient succumbed, in spite of strenuous Roentgen therapy.

792**The Hygienic, Economic and Sociologic Aspect of the Nose.****W. A. WELLS.**

Original contribution to THE LARYNGOSCOPE, p. 42, Jan., 1910.

791**Salivary Calculi.****G. T. WELCH, Med. Rec., March 26, 1910.**

Welch refers to a case which was diagnosticated as inoperable carcinoma, situated at the floor of the mouth, attacking the tongue, the

glands, and the gums. Welch treated the patient with X-ray. He was able to discover one of the ducts of the sublingual gland, which, upon being probed, emitted a fetid liquid, much to the relief of the sufferer. The following day he found the aperture again, and also discovered a hard substance imbedded in the duct about one inch back from the opening. In examining this, the probe tore through the wall of the weakened duct, when a large salivary calculus was exposed. After its removal, the probe was carried down to the gland, and with the finger pressing against the latter, he was able to determine that there was no other foreign substance remaining. The submaxillary gland was also examined by pressure from within and without, but nothing foreign was discovered. Presumably the pressure of a dental plate on the gum, and on the floor of the mouth, brought on the inflammation that caused such a frightful cellulitis, which closed up the ducts of the glands and induced the salts in the saliva, at some stage of the disease, to be precipitated and form the calculus. At this date very little vestige of the original disease is to be found.—*Ex.*

799

Pharyngitis Ceratosa Punctata.

WYSSOKOWICZ AND JANNSEKIEWICZ, *Virchows Arch.*, Bd. 189, Heft 2, and Bd. 193, Heft 1, 1910.

The authors base their remarks on the personal observations of seven cases of this rare pharyngeal affection which is due to micro-organism and is characterized by a slow, almost symptomless course. This disorder appears usually in 20 to 30-year-old females of the "leisure class." Some authors hold that it is due to the proximity of animals—horses, dogs, cats. Its advent is marked by a slight hoarseness, sometimes by the appearance of white patches in the pharynx, sometimes by dryness or prickling sensation in the throat or slight deglutition pains, no fever or general debility.

The clinical aspect is: On the tonsils, uvula, base of tongue, lateral and posterior aspects of pharynx, almost on the vocal cords, greyish yellow deposits are seen. The mucous membrane is slightly inflamed. Microscopic examination revealed the presence of the bacillus ceratosus sometimes associated with the streptothrix buccalis. All therapeutic intervention was ineffectual.

805

Palato-Plastic Operation.

A. CASTEX, *Bull. de Laryngol., Otol. et Rhinol.*, Oct., 1910.

The author discusses the most advantageous time for the operation, the preparation of the patient, anesthetic, mouth-gag and position of patient as well as the three stages of the operation:—Freshening of the edges of the cleft, loosening of the mucous membrane for flaps, and sutures. The author describes the method employed by Ehrmann from which his own differs.

GOLDSTEIN.

812**Simple and Efficient Method of Removing Tonsils.**

D. J. GUTHRIE, *Hospital*, Dec. 3, 1910.

The author favors enucleation especially in adults. He prefers the guillotine, the Mackenzie or the Heath instrument, to all others because it possesses no fork and the size of the ring is smaller than the tonsil. Local or general anesthesia may be used, but the former facilitates the operation.

816**Management of Hemorrhage During Operations on the Tonsils.**

C. J. IMPERATORI, *Med. Rec.*, April 9, 1910.

After the operation it is necessary to examine the coagulability of the blood and prescribe calcium chloride. During the operation the tonsillar region should be well illuminated and tamponaded. If there be a bleeding point it should be compressed with a special instrument or a tampon of adrenalin gauze. One should, if possible, turn or tie the bleeding point.

823**Some Practical Points in the Surgery of the Tonsils.**

W. MILLIGAN, *Med. Chron.*, May, 1910.

After some reference to the anatomy of the tonsils, the writer discusses the part played by them as portals of infection. In his opinion the dangerous tonsils are the submerged and those in which the epithelial lining of the crypts has been weakened by frequent attacks of recurring lacunar tonsillitis.

The author has himself practised tonsillectomy in preference to tonsillotomy for many years. Among the complications hemorrhage is the most serious. In the author's experience the source of it is usually the descending palatine artery, and hemorrhage after tonsillotomy is more severe than after enucleation. He much prefers general to local anesthesia, and favors chloroform rather than ether except when working with a less experienced anesthetist, when ether by the open method, preceded by the subcutaneous injection of atropin is advisable.

GUTHRIE.

827**Simple Process for Removal of Cancer of the Tongue.**

RECLUS, *Gaz. des Hop.*, March 10, 1910.

Report of cases of small circumscribed carcinomata which did not embrace the palatal arches nor the floor of the mouth. Cocain-anesthesia was used. The originality of the procedure consisted in the arrest of the hemorrhage, which the author accomplished by a skillful suture-method.

837**New Procedure for Complete Removal of Tongue in Case of Tumor.**

J. SPIJARNY, *Roussky Vrach*, Jan. 30, 1910.

The author proposes a new technic by which extensive tumors can be removed, and the hemorrhage arrested if it persist after the ligation of the two lingual arteries.

842**New Incision for Epithelioma of Upper and Lower Lips of Same Side.**W. S. SUTTON, *Jour. A. M. A.*, Aug. 20, 1910.Abstracted in *THE LARYNGOSCOPE*, p. 1054, Nov., 1910.Original contribution to *THE LARYNGOSCOPE*, p. 771, Aug., 1910.**846****Enucleation of the Tonsils with the Guillotine.**S. S. WHILLIS and F. C. PYBUS, *Lancet*, Sept. 17, 1910.

By a special method of using the guillotine, the authors have been able in nearly fifty per cent of all cases, including tonsils of all shapes and sizes, to enucleate the tonsil complete in its capsule in one piece. In other cases it is possible to remove the tonsil in two or more pieces even to the last fragment of capsule. They use for their operation ethyl chloride, and when under its influence the patient is turned partly over on to the right side, the head lying on its right side on a level with or slightly above the trunk, so that the cheek pouch is on a lower level than the fauces and that blood may readily collect and run out of the mouth. The gag is then opened. The guillotine, a Lennox Browne's modification of the McKenzie, with the shaft specially thickened, is first used as a tongue depressor and the lowest tonsil seen. The operator stands facing the patient's head and on the right side. The guillotine being held in the right hand, the ring is passed under the lower border of the tonsil, which is pressed upward toward the soft palate. The left index finger is then placed on the outer part of the anterior pillar of the fauces and presses the tonsil into the ring. At this time the blade is gradually pressed home with the thumb of the right hand. It enters between the tonsil and the anterior pillar, cutting the mucous membrane connecting the two. While cutting, the hand is gradually pronated, so that the under surface of the guillotine looks inwardly and finally upward, the tonsils being separated from the pharyngeal wall; the final cut severs the mucous membrane connecting it to the posterior pillar. The tonsil is then lifted out on the under surface of the guillotine, which is now uppermost. The right tonsil, that lowest down, is removed first. To remove the upper tonsil the patient is rolled back so that the head lies in the dorsal position. The patient is readily turned by a nurse who stands opposite the surgeon. The operator now passes to the side of the patient, the guillotine is again inserted, and the ring passed below and behind the tonsil, which is pressed upward toward the soft palate, the left index finger being again used to force the tonsil into the ring. The connections are cut through as described, the hand being meanwhile pronated and the tonsil removed on the under surface of the guillotine, which has become uppermost. Any hyoid projection can now be felt and if present removed. In less than half the cases the tonsil can be felt to slip into the ring, and in these instances it frequently comes out entire. In others it will not wholly engage, and one can say definitely that two or more attempts will be necessary to remove the whole tonsil. The hemorrhage is sharp for the moment, but soon stops entirely. Each tonsil is examined immediately after removal. If incomplete, the remainder, which can be readily felt by the finger inserted between the faucial pillars, is then removed.—*Ex.*

848

Anesthetics in Tonsillectomy.A. WILSON, *Med. Chron.*, May, 1910.

As the operation of Enucleation of the Tonsils is one which requires some minutes for its efficient performance, the choice of anesthetic is limited to chloroform or ether, alone or in combination. Of late years the author has used for all such cases the C. E. mixture, supplemented by chloroform or ether according to the needs of each case.

In regard to the choice between "deep" and "light" anesthesia, the author believes that given a reasonably expert operator and anesthetist, whenever there is likely to be any hemorrhage in the pharynx it is infinitely better that the patient should be in a condition of "deep" or "complete" anesthesia. Under these circumstances even excessive hemorrhage is easily controlled and dealt with by "position" and sponging. On the other hand the coughing, associated with hemorrhage in the pharynx under "light" anesthesia, necessitates deep jerky respirations during which blood may be drawn into the larynx.

Accidents under chloroform are due to either vaso-motor paralysis or cardiac paralysis and can be avoided by extreme watchfulness. Amongst all the difficult cases met with by the author during 24 years as anesthetist he cannot recognize any as having come under the class of Status Lymphaticus.

GUTHRIE.

849

Study of Cysts of the Frontal Sinus.H. ABOULKER, *Rev. hebdomadaire de Laryngol., d'Otol., et de Rhinol.*, Oct. 29, 1910.Abstracted in *THE LARYNGOSCOPE*, p. 84, Feb., 1911.

851

Recognition of Traumatic Mucocoele of Frontal Sinus, Especially its Development.G. BOENNINGHAUS, *Passows Beitr.*, Bd. 3, Hefte 1 and 2, 1910.

Four cases of ectasia of the frontal sinus due to collection of mucus, and points to the development of the mucocoele. If frontal trauma results in headaches or nasal suppuration one should consider the possibility of occlusion of the frontal sinus through consecutive collection of pus. The constant symptom of this condition is dullness of that side. The dilatation manifested itself first through the sloping of the floor of the sinus or through protrusion of forehead.

852

Skull with Frontal Defect Probably Due to Mucocoele.F. H. BOENNINGHAUS, *Passows Beitr.*, Bd. 3, Heft. 4, 1910.

Illustration and description of a skull found in a chapel in which the anterior wall of both frontal sinuses are missing. There is no septum between the frontal sinuses, and the cerebral wall of the left frontal sinus shows a marked defect. The author holds that the defect has arisen through wearing down of the bone by pressure of a mucocoele.

853**Case of Traumatic Frontal Sinusitis.**

F. P. CALHOUN, *Jour. A. M. A.*, Jan. 22, 1910.

Abstracted in THE LARYNGOSCOPE, p. 471, April, 1910.

854**Case of Frontal Sinusitis.**

L. A. COFFIN, *Trans. N. Y. Acad. of Med.*, Jan. 10, 1910.

Abstracted in THE LARYNGOSCOPE, p. 666, June, 1910.

857**Frontal Sinus Empyema a Cause of Epilepsy.—A Case.**

J. J. DOWLING, *Hom. Eye, Ear and Throat Jour.*, Jan., 1910.

Man aged 49, complained of falling vision, with complication of chronic catarrhal rhinitis, pus being expelled from both nostrils daily. Right and left ethmoid cells were involved and also frontal sinus. A few years ago there had been an attack of grip, which resulted in catarrh and "fainting spells." The right frontal sinus was operated. Cure.

859**New Method of Determining Size of Frontal Sinus.**

R. GOLDMANN, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, Sept.-Oct., 1910.

The author has always found auscultatory percussion satisfactory in determining the size of the frontal sinus and in differential diagnosis of affection. He reports two cases in which a diagnosis was thus reached.

860**Eye Symptoms in Diseases of the Frontal and Ethmoid Sinuses.**

A. GUTMANN, *Klin. Therapeut. Wchnschr.*, May 30, 1910.

Report on the eye-symptoms which complicate sinus trouble.

861**Syphilitic Gumma of Frontal Sinus.**

R. HELOT, *Rev. hebdomadaire de Laryngol., d'Otol. et de Rhinol.*, Jan. 15, 1910.

Report of two analogous cases: extensive infiltration of the root of the nose; edema of the upper eye-lid; posterior displacement of bulbar in one case. The presence of periostitis substantiated the diagnosis. The author holds that many cases of suppurative frontal sinusitis are of syphilitic origin.

863**Intra-Nasal Drainage of the Frontal Sinus.**

E. F. INGALS.

Original contribution to THE LARYNGOSCOPE, p. 113, Feb., 1910.

868**Aspiration Method in Frontal Sinusitis Compared to Other Means of Diagnosis.**

MERMOD, *Arch. internat. de Laryngol., d'Otol., et de Rhinol.*, Nov.-Dec., 1910.

A critical review of the value of the various diagnostic methods in the examination of the accessory sinuses. M. places but little reliance on

transillumination; he claims that the X-ray is an invaluable aid in determining the size and shape of the frontal sinus but often uncertain in determining the presence of pus. He emphasizes the practical value of suction or aspiration as an aid to diagnosis in sinusitis and employs this as a routine measure in the following manner:—Exploratory washing of the maxillary antrum is used to determine the presence or absence of pus in this cavity; aspiration is then employed and if pus is found, it must have its origin either in the frontal sinus or in the anterior ethmoid cells. This, in addition to the clinical data, X-ray and other diagnostic signs strengthens our position to-day in diagnosing frontal sinusitis.

GOLDSTEIN.

870

Migraine and Frontal Sinusitis.

OERTEL, *Berl. Klin. Wchnschr.*, June 13, 1910.

In the case described by Oertel there was a chronic catarrhal inflammation of the right frontal sinus entailing periodical attacks of intense migraine, as the secretions accumulated and compressed the nerve terminals in the orbit. Notwithstanding the long duration of the sinusitis there was no pus. The case teaches the importance of examination of the nose and sinuses even with purely functional affections of the eye.—*Ex.*

880

Foreign Body in the Superciliary Region Simulating a Suppurating Frontal Sinusitis.

TAPIA, *Rev. Ibero am. de Cien. Med.*, Feb., 1910.

A young man fell from a wagon and sustained a slight wound in right frontal region. Five months later he suffered severe pain and a swelling formed from which pus flowed. A small fistula also formed. No pus in the nose; the right cavity was occluded. No symptoms pointed to a sinusitis. The fistula canal was dissected as well as the hard (healthy) surrounding tissue. A barley seed was found. Patient quickly recovered.

883

Pus Flooding Gastro-intestinal Tract from Empyema in the Nasal Sinuses.

E. ZABEL, *Deut. med. Wchnschr.*, April 28, 1910.

Zabel has encountered a number of cases of subjective gastric disturbances for which a sinusitis was responsible. The disagreeable sensations were most marked in the morning. Bad taste in the mouth, gases in the stomach, lack of appetite and loss in weight, and altered stomach content is suggestive of chronic catarrh. His experience warns that in all cases of gastric disturbance it is wise to seek for the presence of pus in the nasal apparatus or throat, in the teeth or from a cavity in the lungs. The disturbances in the intestines from this cause may be so serious as to suggest appendectomy.—*Ex.*

885

Symptoms of Tempero-Sphenoidal Abscess.

L. W. DEAN.

Original contribution to *THE LARYNGOSCOPE*, p. 1136, Dec., 1910.

886

Mucocoele of the Sphenoid Cell Complicated Through Neuritis Optica.

M. HAJEK, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Vol. 44, March, 1910.

This case which had as an additional complication a severe ozena, was one in which a diffuse smooth tumor attached itself to the left middle turbinate and occluded the entire olfactory fissure and bordered on the septum. When attacked with an ethmoid crochet a serous mucous fluid immediately issued into the nasal cavity. Tumor recognized as one of the sphenoid sinus. A half hour after the operation the patient could distinguish images with his left eye, which he had been unable to do previously.

889

Carcinoma of the Sphenoid Sinus.

V. NICOLAI, *Arch. ital. di Otol. Rinol. e Laringol.*, Sept., 1910.

Report of a case of large cancer of the sphenoid sinus in a woman, aged 39 years. Removal by repeated fulgurations. In eight months there has been no recurrence.

LASAGNA.

891

New Roentgenographical Method of Demonstrating the Sphenoid Sinus.

W. PFEIFFER, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 3, 1910.

Roentgen photography of the sphenoid sinus, hitherto seldom undertaken, may be performed with the patient's head in a perpendicular position. Then the tube is placed on the head and the cassette in the regio submentalis or vice versa. This method is a supplement to transverse roentgenography and clinical methods.

894

An examination of 240 Skulls with Reference to the Sphenoidal Sinus and the Spheno-Ethmoidal Cell.

W. S. SYME, *Journ. of Laryng. Rhin. and Otol.*, Feb., 1910.

The largest sphenoidal sinus in the series has the following diameters: Antero-posterior, one and three-eighth inches; lateral, one inch; supero-inferior, one and one-quarter inches. In none of the skulls was the sinus found to be entirely absent.

In measurements made from the anterior nasal spine of the maxilla the average distance to the ostium was found to be two and a half inches. In the living subject at least a quarter of an inch should be added to these measurements on account of the soft structure in front of the nasal spine.

The sinuses were rarely of equal size, as a rule the larger sinus extends behind and above the smaller.

The spheno-ethmoidal cell not infrequently encroaches upon the sinus on one or both sides. Normally the sinus is in relation to the carotid tract and to the optic foramen of its own side, but there are many exceptions. The left sphenoidal sinus was found to be in relation to both tracts in twenty-seven instances, and to both tracts and both foramina in four. On the right side the figures are eight and three. The bone

separating the optic foramen from the sphenoidal cavity is generally thin.

Of the main part of the sphenoidal cavity the supero-external boundary is the thinnest, and the roof only a degree firmer. In one skull a large right sinus had no ostium, and in two instances the opening into the sinus is through the sphenoid-ethmoidal cells.

WELLS.

895

Sarcoma of the Sphenoid. A Typical Clinical Picture.

F. VOSS, *St. Petersburg Med. Wchnschr.*, No. 14, 1910.

Report of four unusual cases. The symptoms were severe headache followed by the appearance of tumors on the neck. The naso-pharynx then became involved, the roof sinking. The hearing was also involved. The prognosis is bad, the only hope being an early and extensive operation.

897

Paresis of the Third Nerve and Disease of Sphenoid Sinus.

C. ZIEM, *Med. Klinik*, Feb., 1910, and *Jour of Laryngol., Rhinol. and Otol.*, 1910.

After reviewing the facts known about sphenoid diseases, Ziem reports in detail a case in which paralysis of the oculo-motor nerve pointed to sphenoid disease. Curettage and thoroughly cleansing of the sinus cured the disease and at the same time relieved the paralysis.

898

Relation of Paralysis of Oculo-Motor Nerve to Diseases of Nose Especially of Sphenoid Sinus.

ZIEM, *Med. Klinik*, No. 9, 1910.

Report of a case in which serious disturbances of the oculo-motor nerve-function took place in connection with sphenoid sinus affections.

899

Extensive Mucocle of the Ethmoids and Frontal Sinus.

W. W. CARTER, *Proc. N. Y. Acad. of Med.*, April 27, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 40, Jan., 1911.

902

Globo-Cellular Sarcoma of the Ethmoid and Left Maxillary Sinus.

J. DUVERGER, *Rev. hebdomadaire de Laryngol., d'Otol. et de Rhinol.*, April 9, 1910.

Patient 22 years old, operated four months ago. The operation was very successful as to approach of tumor and cosmetic results and up to the present time the effects have been good. The author minutely describes his technic. He has followed that of Moure.

903

Papillitis Due to Ethmoiditis or Tumor of the Orbit.

N. L. GERLACH and A. DE KLEYX, *Nederl. Tijdschr. v. Geneesk.*, No. 1, p. 405, 1910.

Patient, aged 73 years. Diplopia since five weeks. Chemosis to the left and strong exophthalmus; the left eye is pushed forward towards the

left temporal bone; edema of the left cheek. Chronic ethmoiditis with polyp-formation. Conchotomy of the middle turbinate and cleaning out of ethmoid. The probe is passed from the nose into the orbit, but the eye does not improve. External operation under narcosis. The papyraceous lamina is carious; many nasal polypi are removed; an infiltration but no abscess is found. Improvement during the first fourteen days; then again serious eye-symptoms. Tumor suspected, but none found with Roentgen rays. Operation revealed a large tumor on orbital floor penetrating through to the maxillary sinus. Removal. Microscopic examination showed it to be adeno-carcinoma.

917

Chloroma of the Jaws.

H. A. BRUCE, *Ann. of Surg.*, Jan., 1910.

In a woman, aged 38, suffering from violent neuralgic pain over temporal region, cheek and upper jaw swelling appeared around first bicuspid teeth which soon involved both jaws on the lingual and buccal aspects, the sublingual and submaxillary lymphatic glands. The symptoms grew serious and a septic temperature developed. An operation was undertaken but the woman died a few hours after it.

918

Tumors of the Sub-Maxillary Gland.

CHEVASSU, *Rev. de Chir.*, February and March, 1910.

The author treats tumors in the parenchyma of this gland and records two cases of operative intervention in primary carcinoma of the sub-maxillary gland. He has found five cases of adenoma in literature but he doubts the truth of the diagnosis because of insufficient examination. Two cases of primary cancer of this gland are recorded, one case of papilliferous duct cancer, and another of acinar cancer. The later was operated but the patient died.

920

In this article, Clark reports two cases of what he calls "mucous disease of the antrum." They differ from two similar cases reported by Casselberry in that the latter found a serious discharge coming from the antrum. Clark's cases more closely resemble those reported by Schadle.

Both of the cases reported by Clark were in young women who were under observation for a series of years. They are so similar that a general description will cover both. Frequent attacks of cold and recurrent nasal obstruction had been complained of. A deflected septum with an obstructing basal spur, together with a hypertrophied inferior turbinate, were corrected by operative procedure; but the "colds" continued to recur. Careful examination revealed an edematous condition of the mucosa on the side which had been obstructed before operative correction, and a unilateral discharge escaping from under the middle turbinate, watery in one case, thick and mucoid in the other. A dull pain in the teeth on the same side was complained of; and transillumination showed the corresponding antrum to be slightly darker. An exploratory

puncture of the antrum was made, and on irrigation, "one large mass of thick very tenacious mucus literally flopped like a big oyster into the basin. It had a somewhat reddish brown tinge, probably from blood pigment." Irrigation cleared the condition in two weeks. The first case had four subsequent attacks at intervals of about ten months. Of these, two got well without treatment. All but one attack involved the side toward which the septum had been deflected. When the patient was last seen, almost two years had elapsed since the last attack, and she had experienced no discomfort in that time. The second case had no recurrence for four years, but then irrigation was again required. The condition cleared, but this treatment was of rather recent date, and it is thus too soon to learn whether an absolute cure has been gained.

In discussing these cases, the author refers to their similarity to those reported by Schadle. A point in common was the abnormally large ostium. A thick jelly-like, mucoid mass was also gained from the antrum in Schadle's cases. The writer queries "why the secretion should remain mucous in character no matter how long the trouble persists, and not become purulent, as in the common form of sinusitis." He thinks it may be because the infection is a comparatively mild one. The nasal symptoms are ascribed to the character of the antral discharge, which Schadle found to be acid. An examination of the mucoid mass from the writer's second case showed "that it contained a number of leucocytes, but no bacteria in the smears." Schadle considers the large size of the ostium to be a causative factor. If this be true, the writer adds that "some method for reducing the size of the ostium should aid in a permanent cure." On account of the inaccessibility of the ostium, however, he says that he fears this proposition will prove a difficult one to carry out. MOSHER.

921

Depressed Fracture of the Malar Bone. A Simple Method of Reduction.

E. A. CODMAN, *Boston Med. and Surg. Jour.*, April 21, 1910.

Codman has used this method with complete success: Firmly grasp the bone through the swollen tissues of the cheek with bullet forceps in the manner an iceman holds a cake of ice. The upper prong of the forceps is first inserted just back of the orbital rim and the lower, through the cheek below the prominent part of the malar bone and a firm pull made on the scissor-like handles of the instrument. The bone comes up into place with surprising ease and tends to remain in position when once reduced. No dressing is necessary as the two punctured wounds in the skin made by the points of the forceps are negligible.—
Ex.

923

Report of a Case of Chronic Suppuration of the Antrum of Highmore. Puncture Followed by Septic Pemphigus and Death.

W. L. CULBERT.

Original contribution to *THE LARYNGOSCOPE*, p. 824, Aug., 1910.

924

Radical Operation for Chronic Maxillary Sinusitis Under Local Anesthesia.

A. DENKER, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, July-Aug., 1910.

The author has tried this method in forty cases and found it very satisfactory. A cure was effected in about two weeks and brought about no complications. The author describes minutely the method of injecting and anesthesia and his operative technic.

928

Deformity of Inferior Maxilla Due to Wearing of a Jury Mast by Spondilitics.

L. DURAN, *Rev. ibero-am. de Cien. med.*, Sept., 1910.

The author describes three cases, among the many which he has observed closely. The lesion consisted of a disturbance in the connecting maxillary lamina as the result of a slight bending and thinning of the alveolar process resulting from a distension of the tempero-maxillary articular capsule. Nevertheless these deformities become insignificant when the advantages of this apparatus are considered.

930

Double Fronto-Maxillary Sinusitis; Chronic Suppuration. Operation. Recovery.

G. FOURNIER, *Rev. hebdom. de Laryngol., d'Otol. et de Rhinol.*, Feb. 26, 1910 and *Marseille med.*, April 1, 1910.

The patient was operated in two sittings. The author even calls attention to the mistakes he made. Before the operation, the condition of the patient's mouth was very bad, but Fournier neglected to have the bad teeth extracted. Consequently after the first operation, sequestration took place and the proposed Luc-Caldwell operation became impossible. The operated sinus became infected and recidivation occurred. At the second operation, all diseased tissue was removed, but it was necessary for Fournier to institute a post-operative treatment similar to that following a radical operation on the ear, to obtain the healing of the entire bone-wound per secundam.

931

Case of Columnar Cell-Epithelioma of the Antrum Cured by Radium.

W. FREUDENTHAL, *Trans. N. Y. Acad. of Med.*, Oct. 26, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 211, Feb., 1911.

936

Chronic Antrum Empyema and Ambulatory Treatment.

R. GERDING, *Norsk. Mag. f. Lægevidenskaben*, p. 53, 1910.

In the inferior meatus G. uses an electric trephine according to Max Halle's method to make a large aperture; tamponade; air-douche; recovery in twenty-one of twenty-three cases.

KILB.

938

Three Cases of Trauma in the Antrum of Highmore.

GRAMSTRUP, *Trans. of Dan. Oto-Laryngol. Soc.*, 1909-1910.

A pin had passed through the alveola and the antrum, where the head was fastened in the antrum's wall, and the rest of the pin two and one-half centimetres long was caught below the middle turbinate. KIAER.

940

Report of a Case of Extreme Mal-occlusion with Description of the Measures Taken for its Relief.

J. J. IBBETSON, *Montreal Med. Jour.*, Feb., 1910.

When the child was one year old, there was fixation and lack of development of the mandible. A year later forcible extension of the lower jaw was attempted with but slight improvement in the range of movement. At this time the angle at the junction of the ramus and body approximated a right angle. Deformity due to backward displacement and angulation of the mandible became exaggerated by the practice of pressing the food upwards between the incisors and the hard palate, with flattening of the arch.

At the age of six, the face in profile was a "bird-face." In front the muco-cutaneous margin of the lower lip was invisible, and lay behind the upper incisors, which were with difficulty covered by the upper lip. The temporo-maxillary articulation was apparently completely ankylosed. Skiagrams showed the condyles to be in the normal position but very greatly broadened.

At operation, no trace of the normal articulations could be found. The condyles were excised for about 1 cm., which allowed the mandible to be brought forward. Two permanent lateral splints were inserted on the second day between the upper and lower dental articulations, connected by a narrow body to permit passage of food. Larger splints were subsequently used.

The range of movement and ease of mastication have improved rapidly, and a normal profile will probably be secured with the eruption of the second teeth.

WISHART.

945

Large Congenital Cyst of the Maxillary Sinus of Dental Origin.

E. LABARRE, *Presse Oto-Laryngol. Belge*, Feb. 16, 1910.

The presence of the cyst was detected by the marked deformity of the face. It was removed by the Caldwell-Luc operation.

946

Presentation of an Operation for Bilateral Maxillary Frontal Sinusitis.

LABARRIERE, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, July-Aug., 1910.

The author describes an operation performed upon a young woman. He used a combination of the Killian-Luc method. Complete recovery without recurrence to date—one and a half years.

948

Plastic Closure of the Maxillary Sinus After Radical Operation.

A. LANTENSCHLAEGER, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 62, Heft 3-4, 1910.

After the radical removal of the external wall of the maxillary antrum the author recommends the following plastic operation:—Infiltration anesthesia about the entire circumference of the healed cavity; patient in sitting position. Two oval flaps are made in the mucosa, the lower to within one-half cm. of the upper line of the alveolar process and the upper one cm. from the superior border of the old wound. These oval flaps are then turned inwards and their edges united by thin catgut sutures. This forms a mucosa surface of this artificial wall, pointing into the antrum and the freshly dissected wound surface presents externally.

Over this new muco-elastic diaphragm the free-dissected mucous membrane and tissues of the cheek are pulled slightly downwards and carefully approximated and sutured with fine silk to the wound-margins of the gingiva. Patient is placed on fluid-diet for three days, is forbidden to laugh and the use of the tooth-brush.

The conditions for this operation are:—a thoroughly healed, smooth cavity, absence of all carious teeth or roots and no skin transplantation must have been previously attempted.

GOLDSTEIN.

952

Sarcoma of the Antrum of Highmore.

MALHERBE, *Bull. de Laryngol. Otol. et Rhinol.*, April 1, 1910.

Case of Sarcoma of the Antrum of Highmore in girl of 14 in which the mass extended from the malar bone, causing a protrusion of the eye-ball. Examination of the mouth showed a bulging of the palatine vault. The nasal cavity anteriorly and posteriorly also showed presence of the tumor. By the internal route, a large mass was removed. Uneventful recovery. One year and a half later the tumor recurred somewhat higher in the orbital region and extended toward the nasal fossae. Second operation by the internal route was successful. Second microscopic examination proved same to have tissues histologically of a non-malignant type.

GOLDSTEIN.

955

Pathology and Treatment of Alveolar Abscess.

S. L. McCURDY, *Jour. A. M. A.*, Oct. 8, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1100, Nov., 1910.

960

Radical Cure of Maxillary Sinusitis. Simplification of the Method.

MOUNIER, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, May-June, 1910.

The following conclusions are reached: Luc's radical maxillary sinus operation can be very successfully performed without resecting all or part of the inferior turbinate, without enlarging the passage between the nose and the sinus, and without washing out the curetted sinus. A gauze drain is absolutely necessary, for two or three days, to cleanse the sinus.

965

Intra-Cranial Neurectomy of the Superior and Inferior Maxillary Nerves for Tic Douloureux.F. E. POTTER, *Jour. A. M. A.*, Jan. 1, 1910.

The author cites a case in which the pain was most excruciating, the patient having been operated on at some previous time in which the infra-orbital nerve was cut. This did not seem to alleviate his condition. The author had prepared to do the Cushing operation, but was unable to do so by virtue of the fact that the dura mater around the Gasserian ganglion was very hard and tense and because there was an excessive amount of hemorrhage. He therefore had to content himself with an intra-cranial neurectomy of the superior and inferior maxillary nerves. After dividing these nerves he pushed the severed roots through their exit into the foramina.

At the present time the result of the operation is a success. He concludes that the Cushing operation is the most practical for the entire removal of the ganglion, and his methods the best to follow even if only the nerves are cut.

MYERS (GOLDSTEIN.)

966

Foreign Bodies in the Sinus Especially in the Maxillary Sinus.H. RAZEMON, *Bull. de Laryngol. Otol. et Rhinol.*, Jan., 1910.

Drain having remained in the sinus for twenty years, without causing any trouble until lately, when attention was called to it by an obstinate catarrh. It was removed through the fossa canina.

967

Radical Endo-Nasal Operation for Maxillary Sinusitis.L. RETHI, *Arch. internat. de Laryngol. d'Otol. et de Rhinol.*, Sept.-Oct., 1910.

The author asserts his right of priority to this method, and points out the difference between his method and that of Claoue. Rethi has used this operative procedure in one hundred cases, out of which he has effected ninety complete cures. In the other ten cases the conditions were greatly relieved.

974

Etiology of Gangrenous Maxillary Sinusitis.W. SCHOETZ, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 60, Heft 1, 1910.

Report of a case of gangrenous laryngitis in which innumerable spirilli and fusiform and fungi-form bacilli were found.

976

Bacteriological Examination for Prognosis and Treatment of Chronic Empyema of the Maxillary Sinus.W. SOERNHEIM, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 2, 1910.

Report of bacteriological examination of the contents of the maxillary sinus in twenty-five patients. When the pus is sterile or almost sterile

Sobernheim does not think that extensive operative intervention is indicated. Mere douching or minor operations accomplish satisfactory results.

979

Rapid and Thorough Method of Opening into the Maxillary Antrum in Selected Chronic Case.

D. J. STEIN.

Original contribution to THE LARYNGOSCOPE, p. 127, Feb., 1910.

982

Inflammation of the Sinus Maxillaris with Special Reference to Empyema. The Surgical Pathology, Diagnosis and Treatment.

J. P. TUNIS.

Original contribution to THE LARYNGOSCOPE, p. 931, Oct., 1910.

985

Case of Squamous-Celled Epithelioma of the Antrum of Highmore.

A. P. VOISLAWSKY AND A. BRAUN.

Original contribution to THE LARYNGOSCOPE, p. 129, Feb., 1910.

987

Suppuration of the Antrum of Highmore.

W. A. WELLS, *Med. Rec.* Oct. 29, 1910.

Wells indicates the most desirable and effective methods of irrigating in the various sinus diseases.

989

Osteomyelitis of the Antrum of Highmore.

G. WUESTMANN, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61, Heft 3-4, 1910.

The patient was only 2 years old. Operative interference was indicated and the sinus was thoroughly cleansed. Recovery.

990

Pyemia After Suppurative Maxillary Sinusitis.

J. ZANGE, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, p. 318, 1910.

The author reports two cases. Bacteriological examinations were made of sections obtained.

991

Diseases of the Accessory Cavities as a Cause of Orbital Disease.

S. BENTZEN, *Dan. Klinik*, p. 193, 1910.

Case of empyema of frontal sinus with a fistula in the floor leading to the orbit; abscess retrobulbaris; exophthalmos; operation; recovery.

Empyema of the sinus maxillaris had caused phlegmon in the orbit. Recovery, but with blindness in the eye.

KIAER.

993

Diagnosis of Suppurative Disease of the Nasal Accessory Sinuses.

A. BRAUN, *Med. Record*, July 16, 1910.

A very well illustrated paper, with distinct description of the various sinuses, and the methods of diagnosing their developments. LEDERMAN.

995**Functions of the Pituitary Body.**

H. CUSHING, *Am. Jour. of Med. Sci.*, April, 1910.

The pituitary body has a double function. The secretion of its anterior lobe passes into the blood-sinuses which traverse this part of the gland, while the hyaline substance, apparently the product of secretion from the epithelial investment of the posterior lobe enters the cerebro-spinal spaces by way of channels in the pars nervosa. The secretion of the anterior lobe is by far the most important; for the total removal of this lobe leads to death with a peculiar train of symptoms. Secondary changes in other glands may produce symptoms of disease in the pituitary, and vice versa.

997**Mucocele of the Nasal Sinus and Its Complication by Optic Neuritis.**

R. FULLERTON, *Brit. Med. Jour.*, April 16, 1910.

Detailed report of three cases of mucocele of the ethmoid cells with optic neuritis.

999**Lymph Vessels of the Nasal Accessory Sinuses.**

L. GRUENWALD, *Arch. f. Laryngol. u. Rhinol.*, Vol. 23, Heft 1, 1910.

Man aged 60 years. Gruenwald made some injections, according to Gerotas' method and ascertained that no connecting branch between the alveolus and orbit could be determined. A direct connection between the lymph-system of the accessory sinuses and that of the nose existed only on the level of the mucous membrane and continued in its course, but did not continue through the separating bony wall.

1000**Roentgen Examination of the Accessory Sinuses of Children.**

H. HAIKE, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, p. 206, 1910.

Haike examined the accessory sinuses of one hundred and fifty children of various ages and gives interesting details as to the size at the various ages. He emphasizes the importance of the Roentgen rays in diagnosis. From five observations on children suffering from ozena he concludes that this disease exists even before the development of the sinus and retards its development or even stunts it. Consequently accessory sinus disease should not be diagnosed as the etiological cause of ozena.

1001**Treatment of Empyemata of the Accessory Sinuses of the Nose.**

M. HAJEK, *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzge.*, Vol. 2, Heft 5, 1910.

Of late considerable attention has been paid to the different methods of operation for abscess of the antrum of Highmore and the nasal accessory sinuses. As a rule, severer measures than used to be employed have of late been advocated. It is interesting, therefore, to note that Dr. Hajek recommends that in all cases of chronic suppurative disease of the antrum of Highmore where the origin is dental (and which he holds are more frequent than is supposed), in the first instance a tooth should

be removed and the cavity washed out, as recommended by Dr. Cowper, through an opening in the alveolar process. Failing this, a large number of cases do very well by adopting the modified Mickulicz operation; that is to say, by resecting a portion of inferior turbinated bone, and making a large opening from the inferior meatus, but the opening must be large as there is a tendency afterwards to closing. Of course, Dr. Hajek holds that where the disease is serious and advanced, and where considerable methods have failed, that Denker's modification of the Luc-Caldwell operation is the only one from which complete success may be expected, and failure may easily take place if the complete removal of the affected part be not secured. It is of importance that the opening into the nostrils should be large enough, and low enough down in the inner wall of the antrum to secure complete drainage.

Dr. Hajek thinks that, notwithstanding operation of the most complete nature, patients suffering from ozena do not do well, and that douching after one of the conservative methods is to be recommended.—*Ex.*

1006

Blindness Due to Accessory Sinus Disease.

L. LAUB, *Orvosi Hetilap*, No. 23, 1910.

Eight years previous, lues; since three years, headaches, vertigo and nasal suppuration; edema in frontal region; papillitis in both eyes, though more pronounced in right eye. Much necrotic bone was removed, and both sphenoid sinuses opened. Suppuration of all sinuses except the right frontal sinus. The left sphenoid sinus was scraped. After a fourteen day treatment with douches, much improvement was noticed—a disappearance of headache. The sight, however, only improved after the right posterior ethmoid sinus was punctured which set free a profuse flow of mucous secretion.

1007

Further Study of the Bacteriology of Suppuration in Accessory Sinuses of the Nose.

T. L. LEWIS, *Edin. Med. Jour.*, April, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1083, Nov., 1910.

1008

Visual Fields in Accessory Sinus Disease.

A. M. MACWHINNIE, *N. Y. Med. Jour.*, Aug. 13, 1910.

Report of five cases of sphenoid and posterior ethmoid disease, with charts. The following conclusions are drawn: 1. The central visual acuity may or may not be diminished, although it is usually lessened. 2. Normal visual fields without scotomata would indicate imperfect perimetric chart, hasty procedure, or indifferent taking of the same. 3. The absence of pus in the nose, with or without proptosis, does not indicate a normal sphenoid. 4. Relative scotomata for red or white are always present, regardless of whether the blind spot is enlarged or not. 5. Contraction of the field of vision always for red, maybe for white. 6. Scotomata disappear before the field enlargement takes place, following operative procedures.—*Ex.*

1009**Osteoma of the Nasal Accessory Sinuses with Rare Ocular Complications.**

H. MARX, *Arch. f. Ophthalm.*, Vol. 74, 1910.

The symptoms produced are usually ocular, due to encroachment of the orbital space. Inflammatory symptoms are rarely observed. Marx reports three cases of osteoma successfully treated by operation. In the first the tumor originated in the anterior ethmoid cells, secondarily invading the frontal sinus; in the second, osteoma of the frontal sinus was associated with emphysema of the conjunctiva; and in the third the tumor was of sphenoidal origin, the condition clinically simulating orbital cellulitis. Marx could find only one similar case in literature, an osteoma of the ethmoid reported by Oppenstein.—*Ex.*

1011**Four Fatal Complications of Suppurative Accessory Sinus Disease.**

MEURIERS, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 60, p. 335, 1910.

The author gives a detailed account of these four cases. The first was one of chronic empyema of the right maxillary sinus; the second of double frontal sinusitis; the third of double frontal and ethmoid sinusitis and the fourth one of empyema of the left maxillary and frontal sinusitis.

1021**Further Study of the Bacteriology of Suppuration in the Accessory of the Nose.**

A. L. TURNER AND C. J. LEWIS, *Edin. Med. Jour.*, April, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1083, Nov., 1910.

1024**Diseases of the Accessory Sinuses Causing Ocular Symptoms.**

F. E. WAXHAM.

Original contribution to *THE LARYNGOSCOPE*, p. 132, Feb., 1910.

1029**Value of Vaccine Treatment of Chronic Inflammatory Disease of the Accessory Sinuses of the Nose.**

H. S. BIRKETT AND J. C. MEAKINS.

Original contribution to *THE LARYNGOSCOPE*, p. 857, Sept., 1910.

1030**Auto-Vaccine in Nasal Accessory Sinus Infection.**

F. BRAWLEY.

Original contribution to *THE LARYNGOSCOPE*, p. 877, Sept., 1910.

1031**Treatment of Maxillary Cysts.**

H. BURGER, *Ned. Tydschr. v. Geneesk.*, June, 1910.

For large cysts of the upper maxilla Burger recommends the Partsch operation, and states its advantages. It is usually sufficient to remove

the external wall unless one finds during the operation that the inner wall partially fills the upper maxilla. In that case it too should be removed.

1033

Endo-nasal Operation for Empyema of the Frontal Sinus.

G. A. DENMAN, *Homeopath. Eye, Ear and Throat Jour.*, Jan., 1910.

The author draws the following conclusions: The obstructive lesion interfering with the drainage and ventilation of the frontal sinus is usually not the sinus itself, nor the ostium but the hiatus semilunaris and infundibulum. These obstructions should be removed, without attacking the sinus itself. If the sinus must be treated the Ingals endo-nasal method is preferable because (1) it leaves no scar, (2) it may be performed in the office and the patient is incapacitated for but two or three days, (3) local anesthesia is usually sufficient, (4) the required drainage is established, (5) it is the safest of all endo-nasal methods and in case of subsequent external operation the enlarged drainage canal would lessen its dangers and favor the results, and (6) it facilitates the post-operative washing and cleaning of the sinus.

1036

Ambulant Treatment of Chronic Purulent Maxillary Sinusitis.

R. GORDING, *Norsk. Mag. f. Lægevidenskaben*, Feb., 1910.

Gording describes the intranasal technic with which he was able to cure permanently a long chronic purulent process in the maxillary sinus in 21 out of 23 cases, a proportion of 91 per cent recoveries. This was accomplished without radical intervention, merely by ambulant conservative treatment. He does not think that carious teeth can be incriminated in the etiology of the process to the extent that some accept, as otherwise the sinusitis would be more frequent; fully 70 per cent of all the patients at the clinic in his charge have carious upper teeth while maxillary sinusitis is rare. He opens up the sinus through the nose under local anesthesia, and there is sometimes considerable hemorrhage, requiring careful tamponing. In 2 cases tardy hemorrhage occurred. The opening into the sinus must be made broad enough to allow the entire antrum to be tamponed and a thick drain introduced. The after-treatment consists in alternate tamponing with iodoform gauze, insufflation of air and lavage, the two latter less often, the course requiring from one to five months in all. The process was of many years' standing in every instance, to sixteen years in some. He does not include in this summary a number of patients who have been lost sight of since.—*Ex.*

1037

Simultaneous Operation on all the Accessory Sinuses. (Prosopodiaschise).

C. GORIS, *Presse Oto-Laryngol. Belge*, Feb., 1910.

Bilateral pansinusitis is rare. The author proposes a new operative method which he has employed in two cases of bilateral pansinusitis, inoperable by the usual method.

The first case was completely cured. 1. Preliminary tracheotomy and complete tamponing of the hypo-pharynx. 2. Median incision from the

root of the nose to the upper lip and dissection of one-half of the face into a lateral flap. 3. Removal of the anterior and inner walls of the maxillary sinus, curettage of the sinus, complete tamponage of the naris and sinus. 4. Disposal of the frontal sinusitis by removal of the anterior and inferior walls of the sinus, of the apophysis and of the ethmoid; curettage and complete tamponage. 5. Hemorrhage is controlled by compression of the tampons for several minutes; after removal of tampons the sphenoidal sinus is engaged; removal of inferior wall, curettage; cauterization of the remaining walls with zinc-chloride after which the operated cavities are again tamponed; Procedures 6, 7, 8, 9, are like 2, 3, 4, 5, but on the opposite side. 10. General surgical dressing; cauterization of walls with zinc-chloride; pack with iodoform gauze, muco-cutaneous sutures.

1039

The Endo-Nasal Opening and Treatment of Chronic Frontal Sinusitis.

HALLÉ, *Trans. Berl. Laryngol. Soc.*, 1910.

The intra-nasal opening of the frontal sinus cannot be a substitute for the radical operations, but it may make the latter unnecessary and forestall serious sequelae. Many cases may be cured by this method. (In nineteen cases one was not cured. After many external operations, this case did not yield.)

SAMSON (KUTTNER).

1041

Removal of a Foreign Body From the Maxillary Sinus with the Aid of the Endoscope.

R. IMHOFFER, *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzgeb.*, Bd. 2, Heft 5, 1910.

Report of successful removal of a foreign body by this method. Imhofer is of the opinion that a foreign body which enters a perfectly healthy maxillary sinus always causes suppuration. But all means of removal should be tried before the opening of the fossa canina is resorted to.

1045

Use of Local Anesthesia in Radical Operation for Chronic Suppuration of Frontal Sinus.

H. LUC, *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzgeb.*, Bd. 2, Heft 6, 1910.

Radical operation of both frontal sinuses under local anesthesia in woman aged 33 years. The author believes that local anesthesia will be soon almost entirely used in oto-laryngology except for children and very nervous persons.

1048

Fat-Transplantation After Frontal Sinus Operation.

G. MARX, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61, Heft 1, 1910.

In a boy aged 15 years, the Kuhnt frontal sinus operation was performed, but the wound was not sewed up; an iodoform gauze tamponade being used. After three weeks, when fresh granulations formed, a fat-transplantation was made. The cosmetic result was very satisfactory.

1049

Correction of Deformities of the Maxillae as a Prophylactic Measure.

F. S. McKAY.

Original contribution to THE LARYNGOSCOPE, p. 818, Aug., 1910.

1053

Atypical Accessory Sinus Operations.

PREYSING, *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzgeb.*, Bd. 3, Heft 1, 1910.

In cases of malignant tumors in the nose and accessory sinuses the author urges an almost entire disregard of cosmetic effects. The operative technic is then minutely described. Six cases are reported.

1054

Local Anesthesia in Operations on the Maxillary Sinus.

RAZEMON, *Rev. hebdomadaire de Laryngol., d'Otol. et de Rhinol.*, April 16, 1910.

Abstracted in THE LARYNGOSCOPE, p. 827, Aug., 1910.

1057

Contribution to the Operative Treatment of Hypophysis Disease.

E. SCHMIGELOW, *Hospitalstidende*, p. 1177, 1910.

A woman 27 years of age, blind in right eye and incipient blindness in the left; acromegaly and terrible headache.

Operation by Schloffer's method cystic tumor of the hypophysis cerebri. The headache disappeared and the sight in the left eye was normal, but three weeks later she contracted acute edema of the brain. Death.

KIAER.

1059

Safe Intra-Nasal Method of Opening the Frontal Sinus.

J. A. THOMPSON.

Original contribution to THE LARYNGOSCOPE, p. 810, Aug., 1910.

1063

Amputation of Epiglottitis in Laryngeal Tuberculosis.

L. B. LOCKARD, *Denver Med. Times and Utah Med. Jour.*, Oct., 1910.

From such statistics as are available, it would seem that the general mortality of these cases, including both the incipient and the advanced, is in the neighborhood of ninety per cent. If one took into account the advanced cases only, those associated with severe dysphagia, it would be found that not more than one or two per cent result in local healing. In addition to the failure to cure or even temporarily to arrest the process, little is achieved in the way of relief. Any method of treatment, therefore, that offers some hope of local cure in favorable cases, and promise of euthanasia in the incurable deserves serious consideration, and such a method Lockard thinks we possess in complete amputation. Of the twenty-seven patients operated on by the author, twenty-six were completely relieved of pain; in eight the larynx was cured, and in five the pulmonary process eventually became quiescent; three patients are

still under treatment. In one case the palate was also involved, but even in this instance deglutition was greatly facilitated. Of the cured patients one has endured over five years and one over four years.—*Ex.*

1065

Paralysis of the Vocal Cords with Report of Twenty-two Cases.

H. ABULKER, *Ann. des Mal. de l'Oreille, du Larynx, du Nez et du Pharynx*, June, 1910.

The author states that 30 cases of paralysis of the larynx were observed by him during a space of two years, of which he gives a detailed report of twenty-two. Of these, one was of certain central origin, one of doubtful central origin and twenty of peripheral paralysis. The following table of fourteen male and eight female cases shows the various causes of the paralysis:—Odenopathic Tracheo-Bronchitis, 3; Pulmonary tuberculosis, 7; Unknown Causes, 4; Aneurism of the Aorta, 2; Cancer of the Lung, 1; Hydatid Cyst of the Lung, 1; Cancer of the Esophagus and of the Thyroid Gland, 1; Hysteria, 1; Cerebral Syphilis, 1; Amyotrophic Lateral Sclerosis, 1.

GOLDSTEIN.

1066

Pathological Anatomy of the Vocal Cord.

F. BLUMENFELD, *Ztschr. f. Laryngol. Rhinol. u. ihre Grenzgeb.*, Bd. 3, Heft 3, 1910.

Carcinoma of the vocal cord spreads in its growth in the long axis of the cord; it involves this entirely or to the largest extent before encroaching upon the adjoining tissues and penetrates to the limit of the elastic tissue. This peculiarity of growth of cancer of the vocal cord is dependent upon the arrangement of the sub-mucous lymph-areas by which it is bounded. The upper and lower lines of limitation of incipient carcinoma of the vocal cord form the *liniae acutae superior et inferior* of Reinke which in turn separate the sub-mucous lymph-space of the cords from those of the ventricle of Morgagni and of the sub-glottic mucosa.

These anatomical relations determine an unusual clinical and therapeutic significance for carcinoma of the vocal cord most especially expressed by such favorable endo-laryngeal results.

GOLDSTEIN.

1067

The Diaphragm in Tone-Production. A Fluoroscopic Study.

J. W. BOYCE.

Original contribution to THE LARYNGOSCOPE, p. 457, April, 1910.

1068

Three Cases of Leeches Fixed at the Level of the Vocal Cords.

R. BRAC, *Ann. de Mal. de l'Oreille, du Larynx du Nez et du Pharynx*, April, 1910.

Three patients in whom laryngeal pains, fever, hemoptysis, very abundant salivary secretions and hoarseness were present, and each of whom had a leech fixated at the posterior side of the epiglottis. In one the accident resulted after drinking at a fountain; in another after sleeping near some stagnant water.

1069**Case of Inspiratory Phonation.**

DAGNINI, *Bull. delle Sci. med.*, Sept., 1910.

Patient showed complete dissociation between the functioning of the sphincter of the glottis and that of those expiratory muscles which should set the glottis in motion. On the other hand, there existed a synchronism between the functions of the two muscles which should work independently—the sphincter of the glottis and the inspiratory muscle. Whenever the patient uttered a sound the vocal cords were drawn together and stretched, but vibration was occasioned by one or more inspirations. This condition resulted from a rhinitis.

1070**Case of False Vocal Cord.**

F. S. FLATAU, *Stimme*, Jan., 1910.

Girl, aged 7 years, on whom a tracheotomy was performed, at the age of 4 years, for croup. She wore the cannula for six weeks; it was necessary to dilate the wound because of stenosis; the voice became hoarse and heavy. The cords could not be seen, only the ventricles appeared as strong red bands. Centralized atresia of the trachea. In deep forced respiration a small portion of the left cord could be seen. In phonation, the cords came together, and the larynx was depressed and the epiglottis broke towards the back. Upon cocaineizing the larynx, the ventricle bands separated and the vocal cords were seen to be narrow, dry, pale-red, but intact. By means of orthophonic treatment with his laryngeal electrode, his vibrator and a cord-retractor, the author has achieved very satisfactory results.

1073**Measurement of Relative Intensity of Human Voice.**

H. GUTZMANN, *Passows Beitr.*, Bd. 3, No. 3, 1910.

Until now we have no means of measuring the intensity of the human voice. The measurement of the intensity by respiration for tone of equal pitch and volume gives an idea of the exactitude with which separate tone-intensity may be estimated.

1077**Unilateral Affection of Vocal Cord.**

IMHOFFER, *Arch. f. Laryngol. u. Rhinol.*, Vol. 23, Heft 1, 1910.

The case is remarkable in that no laryngeal symptom was present in spite of the atrophy of the left cord and the redness and roughness of its surface.

1078**The Voice in Laryngostomized Patients.**

A. IWANOFF, *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzgeb.*, Bd. 3, Heft 2, 1910.

The author states that in eleven cases of laryngostomy, his object was to secure a sufficiently large air passage with firm walls to permit the patient to breathe normally. He did not concern himself with saving the vocal cords, because just in their region, the need for radical interven-

tion is greatest yet in each case a gradually increasing return of voice-function, was noted. Through experiments with the phonation registering cylinder of Brueger and Wirth, the author was unable to record even the most minute phonation-vibrations as produced by the reconstructed welts and folds in the tracheae but only a series of air-waves produced by the alternate opening and closing of these folds.

GOLDSTEIN.

1081

Respiration for Tone-Production.

F. V. LAURENT.

Original contribution to THE LARYNGOSCOPE, p. 1118, Dec., 1910.

1085

Photography of the Voice in Medical Practice.

MARAGE, *Gaz. des Hop.*, Feb. 3, 1910.

The advantages, both for the physician and patients of photographing the vibrations of the vocal cords both before and after treatment, are cited in detail. Thus a daily record could be kept.

1086

Vocal Cords in Goiter.

J. MATTHEWS, *Jour. A. M. A.*, Sept. 3, 1910.

Matthews reports observation on the vocal cords in 1,000 cases of goiter examined during the past 2 years. About 95 per cent. of the patients were operated on, and were examined before and re-examined after operation. After describing the motor nerve supply of the larynx and the liability to pressure from goiter, he summarizes his findings. There were 17 cases of paresis of both cords, 93 of the right cord and 162 of the left in the total of 289 partial or complete paralysis in 272 individuals of the 1,000. Total paralysis of the right cord occurred 18 times; of the left, 30 times. Partial or complete abduction paralysis of the right occurred 50 times; of the left 83 times. Partial loss of both motions of the right occurred 38 times; of the left 62 times. Bilateral tensor paralysis occurred in 4 cases. The paralyses were more frequent with enlargement of the right or left lobes. That of the median lobe alone was seldom accompanied by affection of the cords. The average frequency of symptoms of pressure on the nerves was directly proportional to the size of the lobes, but there were exceptions. Paralysis occurred sometimes when the lobe was not palpable, and in some cases with tremendous enlargement there was no affection of the cord. In 100 consecutive cases of non-goiterous patients there were 4 cases of paralysis. The position of the lobes was important. In goiters of the same size the cords were affected more frequently in cases with lobes located near the clavicle, especially if the goiter was wholly or in part intrathoracic.—*Ex.*

1088

Falsetto Voice and its Relation to Spastic Aphonia.

A. MYERSON, *Boston Med. and Surg. Jour.*, Feb. 10, 1910.

Boy aged 14 years. About the onset of puberty he caught a severe cold, involving nose, throat, larynx, and chest, after which he lost the

power of voiced speech. There were no signs of a peripheral neuritis, and the condition was considered as hysterical. Two months' treatment by electricity gave no results. Ten months later it was noted that his voice was not a pure whisper, but tinged with a thin high-pitched squeak. He showed general lack of muscular tone, but on attempting to speak this was replaced by a general spastic condition of the vocal and respiratory organs. No abnormality of action of the vocal cords. Case diagnosed as one of falsetto voice in the male. Proper breathing exercises cured him rapidly, and he now has a good and constant baritone. A good discussion on the functional disorders of speech follows.—*Ex.*

1089

Two Cases of Common Speech and Voice Defect and Their Treatment.

A. MYERSON, *Boston Med. and Surg. Jour.*, Oct. 13, 1910.

These two cases are reported by Myerson, not because they are startling, but because "they represent conditions that on the whole are neglected by the medical profession of America."

The first case is that of a young servant girl of ordinary intelligence, neither deaf nor feeble-minded, whose speech was unintelligible. The writer accounted for it by "some acute illness which came and went unnoticed, left a defect which was neglected, grew worse with the years, and mal-directed her whole life." Examination of the ear, nose, and throat, showed them to be normal. The treatment was re-education. During the four months she had been under the writer's care, improvement, though slow, had been steady, and gave promise of almost a complete return to a normal speech.

The second case illustrates well a different etiology. This patient was a wealthy and cultured woman of 50. Ten years previously she had commenced to suffer from "sore throats" which became more frequent. Until that time she had had no trouble with her voice. Medical treatment was of no avail, and her voice became very weak and practically aphonic. Examination showed a slight imperfection in the adduction of the cords; the larynx was otherwise normal. Phonation was accompanied with a rigidity of the upper chest and neck muscles. She also had writer's cramp. The treatment again was educational, and directed particularly to a correct use of the respiratory muscles. "The result of a month's persistent training was that she was able to pass the following winter without a cold, and she could speak freely and with ease, although her voice remained low, but not aphonic."

The writer discusses the literature with reference to the different respiratory muscles used in tone-production. He distinguishes between the cases above reported, and those of aphonia due to chronic voice fatigue. The former he calls "functional aphonia." He says "a greater proportion of this type than most laryngologists realize, is due to the misuse of the entire speech-apparatus and not to changes in the larynx....The diaphragm, the chest, and the larynx, are all involved in the spasticity, but the larynx suffers most. Moreover, inflammatory and other changes in throat and larynx, associated with pain and hoarseness, are often symptoms of the wrong use of the parts....The method of using any part

that is normally operated by the will can be changed, if it be a wrong method, to a correct one, at least, in most cases. With that change will come a re-adjustment more or less complete of the parts to the normal. This is true in laryngology as in orthopedics, and its recognition has an important bearing on the therapeutics of the future."

MOSHER.

1090

Disturbances in the Singing Voice and Their Cause.

H. MYGIND, *Ugeskr. f. Læger*, June 23, 1910.

The author has treated two hundred and fifty patients, fifty-eight men and one hundred and ninety-two women. Most of the women were suffering from chlorosis—forty per cent—and over-exertion of the voice. In eighty-five cases the voice had been wrongly used; in forty cases, the voice was over-fatigued; in ten per cent of the cases there were knots on the vocal cords. Chronic catarrh of the naso-pharynx has a very great influence on the singing voice, and this condition was found more frequently in women—three:two.

KLAER.

1103

Artificial Production of Vocal Sounds.

O. WEISS, *Med. Klinik*, Sept. 18, 1910.

Weiss indicates various methods for the production of vocal sounds.

Treatment of Asthma.

1106

Two Cases of Papillomata of the Larynx.

H. ABOULKEE, *Bull. de Laryngol., Otol. et Rhinol.*, April, 1910.

The author presents two cases of papillomata of the larynx, one in a child of 3½ years, the other in one aged 12 years, both cured by interventions through the natural passages. In the one child tracheotomy was attempted twice, but was not successful. In the older child removal by means of the Killian tubes was attempted under total anesthesia, but failed because of the opposition which the introduction of the tubes provoked.

1107

Case of Apparently Primary Intra-Laryngeal Actinomycosis.

H. ARROWSMITH.

Original contribution to *THE LARYNGOSCOPE*, p. 977, Oct., 1910.

1108

Peri-Laryngeal Abscesses.

F. BARBERA, *Bol. de Laringol. Otol. y. Rinol.*, Sept.-Oct., 1910.

B. reports minutely a protracted case of retro-pharyngeal abscess (in a breast-fed infant of nine months), following scarlet fever and erysipelas auris. The abscess burrowed downward toward the laryngo-pharynx, produced induration and infiltration of the epiglottis and ary-epiglottidian folds; thus giving rise to the nomenclature by the author of peri-laryngeal abscess.

GOLDSTEIN.

1109**Treatment of Acute Laryngeal Dyspnea in Children.**

H. BARWELL, *Lancet*, Aug. 13, 1910.

The author discourses both on the treatment during the paroxysm and on the preventive treatment. To relieve the spasm he recommends hooking the epiglottis forward with the finger, stimulating the conjunctiva by touching it with the finger or tickling the nasal mucosa with a feather or inhaling amyl nitrite.

Under prophylaxis he urges close attention to diet, a removal into a higher atmosphere, and close examination to detect the presence of adenoid vegetation; as a sedative small doses of bromide are effective.

1113**Paralysis of the Recurrent Laryngeal Nerve and Mitral Stenosis.**

E. BOINET, *Bull. de l'Acad. de Med.*, Oct. 18, 1910.

Boinet reports two cases and discusses what has been published on this subject by Osler and others, all proving that recurrent paralysis is liable to accompany mitral stenosis, either from direct compression of the left recurrent nerve by the left auricle or by traction downward from the dilated and hypertrophied right ventricle or from both these factors. This cause for the paralysis should be borne in mind after exclusion of the usual causes.—*Et.*

1114**Bilateral Posterior and Accessory Nerve Paralysis After Attempted Hanging.**

G. C. BOLTON, *Ned. Tydschr. v. Geneesk.*, Aug. 27, 1910.

Man, aged 53, was brought into hospital in an unconscious state. The next day patient is conscious, but has lost memory. He is suddenly seized with dyspnea and a tracheotomy is necessary. Very soon after the tracheotomy a bilateral posterior nerve paralysis is discovered. From streaks on the neck and inquiry at the home of the patient it was ascertained that he attempted suicide on the previous day but that the rope broke and he was picked up from floor in an unconscious state.

Bolton believes that there was a pressure-neuritis of the accessory nerve which caused the posterior nerve paralysis because the posterior nerve paralysis was the only vagus-symptom. Pressure-paralysis of the recurrent alone is entirely excluded. Two similar cases are cited.

1115**Contribution to Intubation of the Larynx in the Adult. A Case of Neoplastic Stenosis of the Larynx Treated by Intubation.**

A. BONAIN, *Rev. Hebd. de Laryng. d'Otol. et de Rhinol.*, Dec. 10, 1910.

The patient was affected with a very marked stenosis of the larynx, the nature of which could not at first be determined. As his condition, in spite of the negative history, might be due to a syphilitic lesion, intubation was practiced and specific treatment instituted. Repeated in-

tubations were attended with so much success that the improved condition of the patient enabled him to resume his work.

Unfortunately, however, the stenosis was due to a malignant neoplasm as was afterwards shown by a histologic examination, and a general cachexia developed which proved fatal. SCHEPPEGRIEL.

1118

Origin of Laryngeal Tuberculosis.

E. BRANDENBURG, *Med. Klinik.*, April 24, 1910.

Conclusions drawn from three hundred and ninety-three tuberculous cases, of which thirty-six showed laryngeal complications. The author holds that most frequently laryngeal tuberculosis is the result of the continuity of structure from the pulmonary infection.

1120

Is the Recurrent Nerve Exclusively Motor?

J. BROECKAERT, *Bull. de Laryngol. Otol. et Rhinol.*, Jan., 1910.

Although this question is still an open one, still we can, nevertheless, conclude that in man the trunk of the recurrent nerve is a mixed one which holds all the motor nerves of the larynx as well as the motor and sensory nerves of the trachea and esophagus. The sense-perception of the larynx is under the direct or indirect control of the superior laryngeal nerve.

1123

Laryngeal Air-Sacks in Man.

H. BURGER, *Ned. Tydschr. v. Geneesk.*, Sept. 24, 1910.

Boy aged 14 years, suffering from asthma and cough, suddenly felt during an attack of cough, severe pains and noticed a swelling on the back of his neck, which appeared during each attack. Laryngoscopy revealed no abnormalities. A diagnosis of laryngocele proceeding from the right ventricle was made. An air-sack was present which first developed during the attack of coughing. In this case operation was not indicated but would be in cases of internal air-sacks.

1125

Clinical Considerations of Basilar Phlegmonous Glossitis and Suppuration of the Glosso-Epiglottic Folds.

H. CABOCHE, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, July-Aug., 1910.

C. reports several cases. The clinical history of one of his cases, that of a twenty-year-old man, is of interest. The patient suffered from dysphagia and stinging pains radiating to the ear. His head was slightly tilted. Anterior portion of neck swollen. There were slighter pain upon pressure in the upper region of the hyoid bone than further down toward the thyroid gland. This region felt also tense to the touch. There was no change in the floor of the mouth; the tongue could be protruded, though with difficulty. The posterior portion of the tongue was sensitive to pressure, red and swollen. The epiglottis was intact, but immovable. Larynx apparently normal. C. hesitated between a diagnosis of abscess of tongue or pus in the glosso-epiglottic region. The abscess finally ruptured by itself, and the symptoms subsided.

1126**Total Laryngectomy in the Practice of Prof. Jeannel.**CASTETS, *These de Toulouse*, 1910.

Castets numerates the large percentage of cures resulting in the laryngectomies performed by Prof. Jeannel which he traces not only to operative skill but to the treatment before and after the operations, and the avoidance of complications.

1127**Laryngeal Atrophies.**CASTEX, *Le Larynx*, March-April, 1910.

Primary atrophy of the cords is recognized by a peculiar hoarseness in the voice, and occurs most frequently in childhood. An examination during the emission of the sound "e" reveals small thin, pale, weak cords. This condition is usually consequent to an infection, such as measles, diphtheria, typhoid fever, grip, etc., but it may also be congenital. A differential diagnosis must be made between paralytic and tuberculous atrophies. The prognosis must be reserved, for no effective treatment exists. Orthophony alone can develop the voice under such conditions.

1132**Articular Gonorrheal Diseases of the Larynx.**H. CLAUS, *Passows Beitr.*, Bd. 3, Heft 4, 1910.

Porter, 40 years old. Eight days after gonorrheal infection, he had pains and swelling in left knee, in the right middle toe and in the neck. Fourteen days later, pains upon swallowing or upon attempting to speak.

Paralysis of right vocal cord; edema in the region of the right arytenoid cartilage, of the aryepiglottic fold and of the lateral pharyngeal wall. After four weeks restoration of normal conditions in the pharynx and larynx and also in the other diseased portions.

1134**Syphilitic Laryngo-Tracheal Stenosis. Cure by Progressive Dilatation.**COLLET, *Lyon Med.*, May 29, 1910.

Woman 40 years old, presented symptoms of dyspnea and suffocation. Tracheotomy brought no relief. The trachea was then intubated with a No. 24 Nelaton's catheter. Six inches below the tracheal incision, a stenosis was encountered, which, however, the catheter passed. Whereupon perfect respiration took place.

The vocal cords were fixed to the anterior part of the glottis, and the right half of the larynx was almost immobile. Dilatation of the tracheal stenosis was accomplished by the employment, for several weeks, of a catheter daily charged. The laryngeal stenosis was treated by progressive dilatation with O'Dwyer's tubes covered with caoutchouc and introduced through the mouth. The tubes were held in place by a string passed through an eyelet in the tube and fastened to the tracheal cannula. Eventual cure.

The author emphasizes the advantage of using the O'Dwyer's tubes covered with caoutchouc, because they adapt themselves most readily to the shape of the glottis. It was fortunate to have preserved during the whole time the valve-sound—due to the tracheotomy.

1135

Tuberculous Perichondritis of the Cricoid.

COLLET, *Lyon Med.*, May 1, 1910.

Man, 29 years old, tuberculous. By means of the laryngoscope a large tumefaction of the arytenoids, immobility of the vocal cords and retrocricoid chemosis were revealed. General condition very poor. Tracheotomy. Death within seven hours. Autopsy: Pulmonary and pericardial lesions; cricoid cartilage bathed in pus; laryngeal stenosis and dyspnea were the cause of the inflammation of the pericricoid and perichondrium. The arytenoids showed tuberculous lesions.

1136

Case of Suppurative Perichondritis of the Larynx in the Course of Acute Pneumonia. Recovery.

J. COLLIER and H. S. BARWELL, *Lancet*, July 23, 1910.

Case of diffuse pneumonia of the left lung with numerous pneumococci in sputum. On the nineteenth day, inflammation of the neck, swelling of tonsils and cervical glands and edema of pharynx, of epiglottis and of the ary-epiglottic folds. Edema increased on right side. Symptoms of a perichondritis of the thyroid. External incision. Patient coughed up much pus whereupon the dyspnea disappeared.

1138

Primary Arytenoid Abscess.

CURTIL, *Ann. des Mal. de l'Oreille, du Larynx du Nez et du Pharynx*, Oct., 1910.

The author reports a rare case of primary abscess of the arytenoid cartilage in a healthy young woman in which the abscess could be traced to no such cause as grip or any general infection, nor to laryngitis, pneumonia or any foreign body in the larynx. The abscess developed in the course of a week, was entirely localized and was rapidly cured by incision with the galvano-cautery which allowed evacuation of pus. Microscopic examination showed streptococci. GOLDSTEIN.

1139

Course of Laryngeal Tuberculosis with Artificially Induced Pneumo-Thorax.

A. DA GRADI, *Deut. Med. Wchnschr.*, June 2, 1910.

Da Gradi reports three cases of pulmonary tuberculosis in which pneumothorax treatment was applied, and the associated laryngeal lesions healed completely under its influence. He emphasizes that laryngeal tuberculosis should not be regarded as a local process, because it is maintained constantly by the passage of sputum from lesions lower down. If the latter be cured, the laryngeal lesions are liable to subside of themselves.—*Ex.*

1140**Case of Laryngeal Vertigo.**

H. J. DAVIS, *Jour. of Laryngol. Rhinol and Otol.*, March, 1910.

Case, of a man 47 years old, reported to the Royal Society of Medicine. The condition was as follows: Severe subconjunctival hemorrhages, hemorrhage from dilated veins in pharynx, hemorrhage into both vocal cords, slight inguinal hernia, numerous scalp wounds, bruises, etc., the result of falls. A tickling begins in his throat, he coughs for five or ten minutes, then becomes dizzy and insensible. He recovers in a minute feeling "all right." His uvula had been removed, which relieved the conditions somewhat. No signs of disease. Larynx except for hemorrhages was normal; pharynx red and congested.

1141**Laryngeal Neoplasms—A Later Review.**

J. L. DAVIS.

Original contribution to THE LARYNGOSCOPE, p. 439, April, 1910.

1142**Diagnosis and Pathological Findings in an Unusual Case of Epithelioma of the Larynx.**

D. B. DELAVAN, *Interstate Med. Jour.*, July, 1910.

Abstracted in THE LARYNGOSCOPE, p. 1078, Nov., 1910.

1143**Report of the Laryngeal Work of the British Medical Association and of the Sixteenth Annual Medical Congress.**

D. B. DELAVAN.

Original contribution to THE LARYNGOSCOPE, p. 460, April, 1910.

1144**Early Diagnosis and Radical Treatment of Laryngeal Cancer.**

T. DELLA VEDOVA, *Polieclin.*, Dec. Surg., Sec., 1910.

The first symptoms of cancer of the larynx is a change in the voice which too often passes for a catarrhal affection. A hoarse voice indicates a cancer located in the region of the glottis involving the region of the vocal cords, while a guttural tone suggests one lower down. As symptoms are mentioned increasing aphonia, uncontrollable cough, a little pain radiating to the ear, blood-streaks in sputum, dyspnea after exertion, slight spasms of the glottis, especially after coughing. The health may remain good for months or years. Laryngotomy is preferable to a more radical operation, and should be undertaken without delay.

1148**Effect of Pregnancy on Laryngeal Tuberculosis.**

C. R. DUFOUR, *Va. med. Semi-Monthly*, March 11, 1910.

Dufour says that he believes if a pregnant woman with tuberculosis, has had an inflammatory laryngeal condition previously, or if the larynx is chronically inflamed or if it has been weakened from excessive use, there is every reason to believe that this process will become tubercular.

In a survey of the literature he finds that most authorities agree that where laryngeal tuberculosis complicates pregnancy, the woman going to a full term, the mother seldom lives long after the confinement. Laryngeal tuberculosis whether present at the time or developing during gestation, is increased very much during pregnancy. This development of the disease renders suffocation imminent from the edema which often accompanies it. Prof. Kuttner of Berlin, reports 231 cases, 200 of whom died during pregnancy or shortly after confinement. Only three survived a natural confinement for one to one and one-half years. Thirteen lived for a longer period. Among these sixteen women, the laryngeal affection did not commence until the latter part of gestation. Artificial abortion was induced in twelve cases, in nine of them with good results. Tracheotomy was performed fifteen times, eleven of the patients dying soon after.—*Ex.*

1149

Chondroma of Cricoid Cartilage.

A. DURAND, *These de Lyon*, 1910.

The author refers to the first case reported (Travers, 1816). He treats of its etiology anatomo-pathology, symptomatology, diagnosis, prognosis and treatment. Under the last head he points out the indications for the various operative procedures, intra- and extra-laryngeal and laryngotomy. Most chondromata of the cricoid are variable neoplasms; usually benignant except in cases of concomitant adenopathy. The only consequence of chondromata is mechanical stenosis of the larynx. Total removal is always justifiable and laryngotomy is the preferred method. Observations on twenty-four cases are brought forth in evidence.

1151

Case of Laryngeal Epithelioma and Laryngectomy.

F. EGIDI, *Arch. ital. di Laringol.*, Oct., 1910.

Egidi report three cases, and raises the question as to the operative interference, the tracheal wound with its bloody exudate greatly hindering the surgeon. The first case, a man of 38 years, showed an arytenoid infiltration with hoarseness. It was first thought to be tubercular, then syphilitic, and specific treatment prescribed without effect. Suddenly during a cold he developed on the right cord an infiltration resembling epithelioma. Total laryngectomy. Result was entirely satisfactory and the man has resumed his work, making himself well understood by the motion of his lips.

The second case developed less quickly perhaps because of the age of the patient—a man 65 years old. Six months before Egidi saw him, Massel had examined him and found a large vegetation-infiltration of the right cord and diagnosed it as cancer. Voice hoarse, no stenosis. Egidi confirmed the presence of the tumor on the right cord with diffusion of the neoplastic process toward the left and general infiltration. Pronounced stenosis. Immediate operative interference was advised. Fifteen days after the operation the patient returned home.

In the third case, the patient had had a severe laryngeal stenosis for several months. He presented an edematous sub-glottic laryngitis. In-

tubation for three days. After the tube was removed he felt well during the day, but in the evening, a severe pre-laryngeal phlegmon appeared with a doughy swelling, fever and asphyxiant phlegmon. Intubation by means of Schrotter's dilator; then tracheotomy by the aid of it. The phlegmon decreased after an exudate of much cellular spatulated tissue. After the edema disappeared one could see an epithelial tumor occupying and obstructing almost the whole larynx; but the patient refused operative removal.

1152

Unilateral Laryngeal Paralysis.

G. FERARRI, *Riforma Med.*, June 13, 1910.

An interesting case of what F. calls the Longhi-Avellis syndrome in a farmer of 50 years of age. There was first abducent paralysis and paralysis of the velum, lasting for about five years with no other symptoms except occasional dizziness, until an intense headache was followed by complete paralysis of the face and shoulder and vocal cord on this side. He compares this case with those on record, explaining the disturbances as the result of a toxic infectious neuritis of the branches of the spinal nerve involved, gradually extending backward to the nucleus.—*Ex.*

1155

Report of Two Unusual and Interesting Cases of Acute Edema of the Larynx.

H. FOSTER.

Original contribution to THE LARYNGOSCOPE, p. 154, Feb., 1910.

1157

Development of the Larynx.

E. FRAZER, *Jour. of Anat. and Physiol.*, Jan., 1910.

Eight embryos, five to thirty-five mm. long, were dissected, horizontally and vertically and thoroughly examined; from which Frazer concludes: A bronchial arch forms in the back and later also on the inner side of the fourth. The pulmonary diverticle rises between both fifth arches on the floor of the pharynx and in back of a central mass. Its end is drawn out and thus forms the laryngeal cavity under the true vocal cords and arytenoid cartilage, while the opposite portion is a part of the pharyngeal cavity, which is enclosed by the forward growth of the united ends of the fourth and fifth bronchial arches. The true vocal cords form in the fifth bronchial arch, after the notochord. The ventricle is a protrusion of the laryngeal cavity just above the true cords; they are not formed from the same bronchial arch. The thyroid cartilage forms in the fourth bronchial arch, the ring and arytenoid in the fifth.

1159

Laryngitis Dolorosa.

W. FREUDENTHAL, *Ann. of Otol. Rhinol. and Laryngol.*, Sept., 1910.

Abstracted in THE LARYNGOSCOPE, p. 1089, Nov., 1910.

1160**Neoplasms of the Larynx.**

W. FREUDENTHAL, *Trans. N. Y. Acad. of Med.*, Jan. 10, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 666, June, 1910.

1166**Direct Laryngo-Tracheo-Bronchoscopy and Esophagoscopy: Report of Cases.**

L. J. GOLDBACH.

Original contribution to *THE LARYNGOSCOPE*, p. 890, Sept., 1910.

1167**Lipoma of the Larynx.**

M. A. GOLDSTEIN, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Heft 1 and 2, 1910.

Original contribution to *THE LARYNGOSCOPE*, p. 641, Sept., 1910.

1168**Central Paralysis of the Laryngeal Muscles. The Rosenbach-Semon Theory.**

GRABOWER, *Arch. f. Laryngol. u. Rhinol.*, Vol. 23, Heft 1, 1910.

Grabower disputes Koerner's conclusion that Rosenbach-Semon law does not apply to central paralysis. He admits however, that the law only applies where the entire nucleus of the recurrent nerve is diseased, while it is possible that syringo-bulbia is limited to one portion.

1169**Dysphagia in Tuberculosis.**

GRABOWER, *Ztschr. f. Ohrenh. u. f. Krank. der Luftw.*, Bd. 60, p. 55, 1910.

Grabower recommends Bier's hyperemia treatment. In seven of his advanced pulmonary cases in which there were serious laryngeal changes, the dysphagia was entirely relieved through this treatment. After several weeks the edematous portions were reduced.

1171**Stenosis of the Larynx.**

H. GRAFF, *Muench. med. Wchnschr.*, Dec. 13, 1910.

In Graff's first case the stenosis was the result of lordosis of the cervical vertebrae in a man of sixty, the disturbances coming on gradually in the last two years. In the second case a young man awoke one morning with signs of stenosis ascribed to angina and laryngitis and a tuberculous process was assumed at first. The dyspnea became so intense that by the end of six weeks tracheotomy had to be done and the patient had to wear a cannula permanently. An inflammatory process was treated in various ways with no effect and attempts to dilate the stenosis proved ineffectual. In order to exclude an inflammatory process in the vertebrae, the patient was examined with the Roentgen rays when a foreign body was discovered, which proved to be the metal stopper of a mineral-water bottle. When the patient was shown the foreign body, he

remembered that he had been drinking mineral water the night before the first sign of trouble and felt that he had swallowed something like a crumb at the time, but had quite forgotten it. The foreign body had penetrated the wall of the trachea and lay close to the spine, without injury to the esophagus. It took over two years to relieve the patient from the necessity of wearing the cannula.—*Ex.*

1172

Laryngocele.

J. GUGENHEIM, *Arch. f. Laryngol. u. Rhinol.*, Vol. 23, Heft 1, 1910.

Case of a haultoy blower, 29 years of age, in whom a semi-spherical swelling appeared first on the right side and later also on the left.

1173

New Cases of Diagnosis by Means of Direct Laryngoscopy Not Possible with Mirror.

GUISEZ, *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzgeb.*, Bd. 2, Heft 6, 1910.

Guisez mentions several cases of papillomata in children and two cases of tracheal stenosis after tracheotomy. In another case—a child of eight months—examination showed normal conditions in the larynx and trachea. The Gottstein operation was performed. The severe respiratory disturbance disappeared. In an adult in whom an examination with the laryngeal mirror was impossible, the larynx could only be seen by direct laryngoscopy and a diagnosis of epithelioma of the vocal cord was thus made.

1175

Binocular Stereoscopic Examination of the Larynx Epipharynx and Tympanum.

HEGENER, *Passows Beitr.*, Bd. 3, No. 3, 1910.

New instruments constructed for Hegener by Zweiss of Jena.

1176

Laryngeal Arthritis.

HERYNG, *Medycyna*, No. 26, 1910.

Report of two cases of laryngeal arthritis in singers. Both cases recovered.

1177

Laryngocele in the Human.

R. VON HIPPEL, *Deut. Ztschr. f. Chir.*, Nov., 1910.

Hippel devotes nearly a hundred pages to this rare anomaly, his attention having been called to it by a case personally observed.—*Ex.*

1179

Papilloma of the Larynx.

J. HOLINGER, *Trans. Chicago L. and O. Soc.*, May 17, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 113, Feb., 1911.

1182**Suture of the Recurrent Laryngeal Nerve.**

J. SHELTON HORSLEY, *Ann. of Surg.*, April, 1910.

The author reports a case in which he sutured the recurrent laryngeal nerve three months after it had been injured by a pistol ball. Before the operation the patient showed a complete paralysis of the left vocal cord. After the operation there was complete recovery of the voice and the vocal cords regained perfect motility. Dr. Horsley excised about one-half inch of the nerve which was found involved in a mass of scar-tissue. He sutured the severed ends with chromic catgut. **PACKARD.**

1183**The Relief of Pain in Tuberculous Disease of the Larynx.**

W. G. HOWARTH, *Practitioner*, p. 155, 1910.

The writer is inclined to advocate Bier's method of congestion hyperemic before resorting to surgical measures or the injection of alcohol into the internal branch of the superior laryngeal vein before it pierces the thyro-hyoid membrane—a method introduced by Hoffman.

Bier's method is simple. A sample elastic band one inch wide, fitted with a small pad which lies in the notch between the cricoid and sternum, and provided with a hook-and-eye attachment behind to regulate the tightness, is the only apparatus required. The band is worn tight enough to produce a slight flush above the region contracted. In about four days the band can be worn for twenty-two out of twenty-four hours and in many cases with extraordinarily good results in the relief of pain on swallowing. **TILLEY.**

1188**Further Remarks on Laryngostomy.**

A. IWANOW, *Russ. Monatschr. f. Ohrenh.*, No. 3, 1910.

The author adds an account of three new cases to the eight cases of laryngostomy reported by him the previous year and indicates an improvement in his operative technic.

1189**Case of General Papilloma of the Larynx Complicated by Extrinsic Carcinoma.**

JAUQUET, *Clinique*, Jan. 22, 1910.

The case is of interest because of the simultaneousness of both tumors of different tissue-formation and the question of their chronological sequence; and especially because by means of the operation the author strengthened the argument of those who recommend immediate laryngostomy in cases of generalized papillomata.

1190**Extension and Flexion in Direct Laryngoscopy.**

R. H. JOHNSTON, *Ann. of Otol., Rhinol. and Laryngol.*, March, 1910.

The author recommends Jackson's instrument. But the head should be bent forward, if possible, and no anesthesia should be used unless absolutely necessary.

1191**Straight Method of Direct Laryngoscopy.**

R. H. JOHNSTON.

Original contribution to *THE LARYNGOSCOPE*, p. 1126, Dec., 1910.**1192****Use of the Faradic Current in the Treatment of Persistent Aphonia Following Laryngitis.**F. H. JOHNSON, *Lancet*, Nov. 5, 1910.

A study of two cases of aphonia has led Hernaman-Johnson to form conclusions regarding the pathology and treatment of persistent post-catarrhal aphonia. The larynx is primarily a mechanical device for the production of vocal sounds, and depends for its proper functioning even more on the integrity of its muscles and nerves than on the healthiness of their covering. In chronic catarrh of this organ, the muscles become secondarily affected, and the delicate terminals of the motor nerves in all probability undergo an inflammatory degeneration. An acutely inflamed mucosa doubtless demands local sedative applications; and even when the trouble has become chronic, astringent sprays, paintings, etc., can often play an important part. But the tendency in many chronic cases is for the mucous engorgement to disappear to a great extent, whereas the damage to the neuromuscular apparatus remains. Under such circumstances it is unreasonable to expect a cure by the ordinary means. On the other hand, improvement may be looked for from such measures of "natural therapy" as produce benefit in similar pathologic conditions elsewhere, e. g., in the form of facial palsy which is the result of exposure to the cold. Hernaman-Johnson says that in treating paresis of laryngeal muscles by faradization, the secret of success lies in the regular and persistent use of mild currents, which are not calculated to produce violent contractions of opposing healthy muscles. If carefully applied for a prolonged period this form of electricity exercises a selective action on the affected structures and eventually restores their tone. Remarkable as are the results in suitable cases, however, it must not be regarded as a panacea for each and every form of catarrhal aphonia. When the laryngoscope shows marked swelling and congestion of the cords, the mucous membrane must be attacked vigorously on orthodox lines. Nevertheless, even when the mucosa is the part most at fault, the judicious use of the interrupted current, he declares, forms a valuable adjunct to routine treatment.—*Ex.*

1195**Case of Bilateral Paralysis of the Larynx, Tongue and Lips. Recovery. Remarks on the Rosenbach-Semon Law.**O. KOERNER, *Ztschr. f. Ohrenh. u. Krankh. der Luftw.*, Bd. 61, Heft 3-4, 1910.

1205

Per Cent of Tubercle Bacilli in the Mucous Membrane of the Larynx.

K. LUNDH, *Ugeskr. f. Laeger*, p. 59, 1910.

In sixty-six patients with pulmonary tuberculosis without expectoration, the author examined the mucous of the larynx and found tubercle bacilli in eleven per cent; but these seven patients were all in the second or third stages.

KIAER.

1208

Foreign Body Loose in the Larynx and Another Tightly Lodged.

F. MALTESE, *Arch. ital. di Otol., Rinol. e Laringol.*, July, 1910.

Case 1. Boy, aged 3 years. Aspirated a pumpkin seed into trachea. Continual cough, dyspnea. Tracheotomy. Foreign body was coughed up through tracheotomy wound. Recovery.

Case 2. Boy, aged 3½ years. Corn seed tightly lodged in larynx. Stenosis, hoarseness, pains. Removal through laryngo-fissure. Recovery.

1215

Acute Edema of the Larynx Following Etherization for Forceps Delivery.

N. R. MASON and H. J. INGLIS, *Boston Med. and Surg. Jour.*, June 2, 1910.

Patient aged 25, with a family history of pulmonary tuberculosis. She had a moderate naso-pharyngitis, which caused her much annoyance from nasal obstruction during her pregnancy. Full ether anesthesia was induced for an hour and a half. The anesthesia was taken badly breathing being difficult, with cyanosis. It was followed by an acute laryngeal edema, which lasted some forty-eight hours, and was rapidly recovered from.—*Ex.*

1218

Disturbances in the Sensibility of the Larynx and Anesthesia of the Vestibule in Paralysis of the Recurrent.

F. MASSEI, *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzgeb.*, Bd. 3, Heft 1, 1910, and *Bol. delle Mal. dell'Orecchio della Gola e del Naso*, April, 1910.

Massei enlarges upon all the points which endorse his view that in paralysis of the recurrent nerve anesthesia of the vestibule of the larynx occurs; thus contradicting Iwanoff's theory.

1221

Fractures of the Larynx.

L. MICHEL, *Rev. Med. de l'Est.*, Feb. 15, 1910.

Report of five cases of fracture of the larynx, three of which were operated by the author. The first succumbed, in spite of tracheotomy, to pulmonary congestion. The other two were cured. One of the other two, which were not operated, presented a very benignant fracture and the other a subcutaneous emphysema which healed. The author gives an historical review of the cases recorded and discusses their prognosis and treatment.

1222

Laryngeal Signs of Tuberculosis.

C. L. MINOR, *Jour. A. M. A.*, Nov. 19, 1910.

The symptoms of early laryngeal tuberculosis are limited in number and not so valuable as the signs. The earliest is usually a mere weakening of the voice, which may appear long before hoarseness is noted. Next to this he would note a sense of dryness in the throat followed by a localized tickling or pricking. Pain on swallowing is not usually an early symptom in his experience. The subjective symptoms, however, are relatively unimportant as compared with the objective signs. He has not found pallor of the mucous membrane often as an early sign, and he believes that catarrh with hyperemia is usually the first sign, though it is not diagnostic. It is only when it becomes unilateral and persistent that it becomes really suspicious. An obstinate patchy catarrh confined to one cord is highly suspicious, and in a patient whose lungs are tuberculous may be safely counted as tuberculous itself. Next to this he would note as significant a grayish wrinkling of the posterior commissure, which he thinks is the commonest early finding, but it is not diagnostic. The earliest real diagnostic symptom is, in his experience, a table-like elevation of the mucous membrane in the posterior commissure, and this he believes is pathognomonic. These tend to break down into ulcers and, with their abundant granulations, they may pass for tuberculomata. Next as a site of early changes is the vocal process, the posterior insertion of one cord or the body of the cord itself, where ulcers tend to appear which may be scattered along the edge. He finds some involvement of the arytenoid region very early in the disease, localized congestions or thickenings. Thickening of the ary-epiglottic folds is a more advanced change, but when present is pathognomonic. Another early change, though a rare one, is the protrusion of a small point of red granulation beneath the anterior commissure, and when seen its diagnostic value is great. In the therapeutics of this stage Minor insists first on absolute rest of the voice, not allowing even whispering; next the avoidance of all irritants, especially smoking, and third, cleanliness; fourth, the use of astringents.—*Ex.*

1226

Foreign Body in the Larynx.

S. H. MONSON, *Cleveland Med. Jour.*, June, 1910.

Female child, aged 6 years, in whose larynx a piece of tinfoil remained lodged for three months, the child dying a few days after a low tracheotomy.—*Ex.*

1227

Enchondroma of the Larynx.

E. J. MOURE, *Rev. Hebd. de Laryngol., d'Otol. et de Rhinol.*, Aug. 20, 1910.

Moure reports a case of very large lobated enchondroma of the upper portion of the larynx, attached to the left aryteno-epiglottic fold and the left wing of the thyroid cartilage. Preliminary tracheotomy was performed. Three weeks later the removal of the growth was under-

taken by external access under local anesthesia. The growth was so large that it had to be removed piece-meal, and some of the pieces, being too voluminous to be removed through the thyroïdal incision, had to be pushed into the mouth, whence they were expectorated. After some tribulation the patient made a good recovery, but it was some time before he could be relieved of the tracheal cannula.—*Ex.*

1228

Large Enchondroma of the Larynx.

MOURE and DAURE, *Jour. de Med. de Bordeaux*, Jan. 16, 1910.

Tumor of larynx in man of 62 years. He had noticed the growth six years ago but had only been troubled by it—by hoarseness, dysphagia, etc.—for the last two years. Thorough laryngoscopic and radioscopy examination. Tracheotomy. Removal, of which a detailed description is given. The tumor was found to be a typical chondroma.

1230

Anastomosis of the Inferior Laryngeal Nerve with the Descending Branch of the Hypoglottical by Nerve Suture.

D. VON NAVRATIL, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 3, 1910.

See abstract 1549, page 501.

1235

Psoriasis of the Larynx.

G. PALUDETTI, *Arch. Ital. de Laringol.*, July, 1910.

Case 1. Man aged 59 years. Simultaneous to the cutaneous affection an eruption of like nature occurred in the larynx. Greyish eruptions of various sizes also on vocal cords. Wassermann positive. Improvement after five month's treatment. Etiological cause, syphilis.

Case 2. Woman aged 23 years. Suffered from cutaneous psoriasis for many years. Since three months eruptions also in larynx. Treatment thus far without avail. Author believes it to be of idiopathic origin.

1238

Process of Hyalin and Amyloid Degeneration of Neoplasms of the Larynx.

G. PINAROLI, *Arch. Ital. di Otol., Rinol. e Laringol.*, Sept., 1910.

The cause of this local degeneracy which Pinaroli has found to exist, is most likely a local trophic tumorous disorder rather than a general infection or intoxication.

1240

Cases of Laryngeal Tumor with Remarks on the Technic of Their Removal.

W. G. PORTER, *Edin. Med. Jour.*, March, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 991, Oct., 1910.

1245

Permanent Anesthesia of the Larynx with Alcohol.

G. ROTH, *Muench. Med. Wchnschr.*, Oct. 18, 1910.

Roth thinks that the anesthetization of the larynx by the injection of alcohol down upon the superior laryngeal nerve is a simple procedure

devoid of danger which is a valuable aid in the suppression of the troubles of swallowing in cases of laryngeal phthisis, and that it should not remain untried when other means employed to control the dysphagia have failed.—*Ex.*

1247

Laryngeal Cysts.

W. SALOMON, *Ztsch f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 62, Heft 1, 1910.

This is an extensive monograph in which the etiology, classification, pathology, symptoms and diagnosis, of cysts of the larynx are minutely described. The author contributes a new case of laryngeal cyst in a twenty-eight-day old female infant, probably congenital in character. The neoplasm nearly completely filled the left pyriform sinus and the majority of the superior surface land-marks of the larynx were obliterated. The right half of the larynx appeared normal.

GOLDSTEIN.

1249

Case of Glosso-Laryngeal Hemiplegia Tapia's Syndrome.

SANZ, *Rev. espanola de Laryngol. Otol. y. Rinol.*, July-Aug., 1910.

Ulcerous tumor which embraced the right epiglottis and glosso-epiglottic fold. Tracheotomy. After some time and as a result of the lymph-gland metastasis paralysis of the right half of the tongue with incipient atrophy, as well as paralysis of the right vocal cord, which the tumor had now also attacked.

1251

Endoscopic Examination of the Larynx and Pharynx.

SCHEIER, *Trans. Berl. Laryngol. Soc.*, March 18, 1910.

The use of the endoscope requires the same technic as that employed in the use of the mirror and entails the same difficulties that are encountered in other methods. At best the endoscopic method may be of value in clinical cases where there is difficulty in opening the mouth, as in severe tonsillar abscess or in cicatricial closure of the jaw.

SAMSON (KUTTNER).

1252

Ossifying the Larynx.

SCHEIER, *Trans. Berl. Laryngol. Soc.*, May 27, 1910.

The two sexes show marked differences in the development of ossification of the larynx, and in many cases these differences are very noticeable after the thirtieth year, and earlier. There are cases in which the area of ossification about the thyroid cartilage makes it difficult to decide as to whether the larynx is that of a man or a woman.

SAMSON (KUTTNER).

1253

Cicatricial Stenosis of the Larynx After Attempted Suicide.

SCHMIEGELOW, *Trans. of the Dan. Oto-Laryngol. Ass'n.*, 1910.

The stricture was dilated with a drain, a demure, which was transfixed by means of a silver wire. Recovery.

KIAER.

1254**Clinical Contributions to the Pathology of Cancer of the Larynx.**

E. SCHMIEGELOW, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 3, 1910, and *Ugeskr. f. Laeger*, July 14 and 21, 1910.

Forty-eight cases of primal laryngeal cancer, in forty men and eight women, only three of the patients being under forty years. In twenty-three cases the vocal cords were the place of origin. Twenty-five times endo-laryngeal proof-excision was made with a finding of epithelioma, alveola carcinoma, three times; adeno-carcinoma twice and medullar carcinoma once. In thirty-four cases the cancer was removed, twenty times through thyrotomy with ten recoveries. S. considers laryngeal cancer as a relatively benign disease being early diagnosed and operated on. Laryngeal cancer in its first stage can be removed by a thyrotomy with a specially good result in regard to the function and to life.

KIAER.

1255**Etiology of Gangrenous Laryngeal Inflammations.**

W. SCHOETZ, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 60, p. 41, 1910.

In two cases of noma of the larynx, (the one a case of pulmonary tuberculosis, the other one of pulmonary infection), the author found fusiform Vincent's bacilli, and believes that to their presence is to be attributed the gangrenous inflammation of the neighboring regions of the mouth and larynx.

1258**Case of Laryngeal Carcinoma Under Observation for Thirteen Years.**
H. SMITH.

Original contribution to *THE LARYNGOSCOPE*, p. 139, Feb., 1910.

1263**Foreign Body Impacted in the Larynx for Six Years.**

G. SPIESS, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 3, 1910.

Seven-year-old child who had been wearing a tracheal cannula for six years. A Roentgen examination revealed the presence of a button in the left bronchus. Removal. Complete recovery.

1268**Case of Hemi-paralysis of Larynx and Tongue Without Paralysis of Velum.**

TAPIA, *Rev. Clin. de Madrid*, June, 1910.

Man, aged 49 years. As a result of an epithelioma on the lower pole of the right tonsil which also embraced the glosso-epiglottic fold, a unilateral paralysis of the larynx and tongue took place. The velum palati, however, was not affected.

1270**Total Removal of Larynx at Two Sitzings.**

G. TAPIA, *Ann. des Mal. de l'Oreille du Larynx du Nez et du Pharynx*, April, 1910.

Great caution had to be used in performing the tracheotomy because of the sudden asphyxia. This is an indication for operating on carcinoma in two stages.

1274**Spasms of Glottis During Fatal Broncho-pneumonia of Measles.**

VARIOT and PIRONNEAU, *Gaz. des Hop.*, Sept. 22, 1910.

Child of 4 years having measles and secondary broncho-pneumonia. When the general symptoms tended to allay themselves, pertussis, loss of voice, and violent dyspnea necessitating intubation set in. However, symptoms of diphtheritic laryngitis or a simple inflammation were not present. The child succumbed to a broncho-pneumonia. Autopsy: Larynx, entirely intact, no tracheo-broncho adenopathy to explain the previous symptoms. Therefore the author feels that a reflex glottic spasm was the cause.

1275**Eight Cases of Laryngostomy with Dilation.**

C. VIANNAY, *Lyon Chir.*, Nos. 1 and 2, 1910.

All of Viannay's patients are in good health to date except that one patient succumbed to an accidental pneumonia six months later. He reviews the cases in detail with the technic. He prefers to close the wound definitely at once when possible.—*Ex.*

1277**Abscess of Larynx with Report of a Case.**

WATERMAN, *Ann. of Otol. Rhinol. and Laryngol.*, Sept., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1084, Nov., 1910.

1282**Report on First Suture of Ends of Recurrent in Man Performed by Shelton Horsley.**

A. WETTSTEIN, *Med. Klinik*, No. 31, 1910.

In a woman, aged 40, the left recurrent nerve was split by a gun-shot wound. Hoarseness. When the patient came under Horsley's treatment she had dyspnea and her voice was only a whisper. At the operation, it was found that the recurrent before its entrance into the larynx was entirely split. The ends of the nerve were sutured with catgut. Fifteen months after the operation the vocal cords functioned normally and the dyspnea had entirely disappeared.

1288**New Contribution on the Value of Direct Laryngo-Tracheoscopy and Bronchoscopy.**

A. WINTERNITZ and M. PAUNZ, *Orvosi Hetilap*, No. 23, 1910.

Report of two cases of laryngeal papillomata in children and of the removal by means of Bruening's instrument of a bone from the larynx,

a button from the left bronchus during broncho-pneumonia and beans from the right bronchus all by means of superior tracheo-bronchoscopy. By means of inferior tracheo-bronchoscopy the author removed a bean from the right bronchus, and pumpkin seeds from the right and from the left bronchus. By dilating the tracheal fistula they removed a broken coral from the left bronchus.

1290

Papilloma of the Larynx with Symmetrical Papillomata on the Palate.

A. WYLIE, *Proc. Roy. Soc. of Med.*, March 4, 1910.

Wyllie reports the case of a cab-driver, aged 40 years, with hoarseness of eight months' duration, and attacks of dyspnea latterly on lying down. A large subglottic papilloma was seen in the anterior commissure of the larynx, and there were two papillomatous growths on the edge of the soft palate at equal distances from the uvula.—*Ex.*

1291

Recent Progress in the Knowledge and Treatment of Diseases of the Upper Respiratory Tract.

S. YANKAUER.

Original contribution to *THE LARYNGOSCOPE*, p. 788, Aug., 1910.

1298

Foreign Body in the Left Bronchus Removed by Bronchoscopy.

E. BOTELLA, *Rev. Espanola de Laringol.*, No. 1, 1910, and *Arch. Internat. de Laryngol. d'Otol. et de Rhinol.*, March-April, 1910.

Boy, aged 11 years. After repeated attempts at bronchoscopy the foreign body—a whistle, made of small pieces of reed, attached by a string—was finally removed under local anesthesia from the left bronchus.

1301

Death in a Case of Superior Bronchoscopy.

O. CHIARI, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 8, 1910.

Child aged 7 years, aspirated a grain of corn which lodged in the left bronchus. Bronchoscopy under local anesthesia was undertaken but as this did not suffice Billroth's mixture was given, and a portion of the foreign body removed. During the procedure the child suddenly stopped breathing and no pulse could be felt. All restoratives were ineffectual. Autopsy: Grain of corn firmly impacted in left bronchus; purulent bronchitis on left side. The author explains the fatal termination as due to the child's debilitated condition and the lengthy manipulations—one hour—and not to the general anesthetic.

1302

Two Cases of Foreign Bodies Removed by Bronchoscopy Several Years After Their Entrance.

O. CHIARI, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Heft 1, 1910.

In the one case a plate with two teeth which had been in the lower bronchus for seven years was removed, and in the other, a note-book clasp which had caused purulent bronchitis of two years' standing.

1303**Foreign Body in Right Bronchus. Removal. Recovery.**

L. DELLA VALLE, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, Sept.-Oct., 1910.

Child of 7 years, swallowed a kidney bean; whereupon suffocation, cough, and violent vomiting took place, which however, soon subsided. Two days afterwards stenosis of right bronchus. Removal of bean by tracheotomy. Sub-glottis edema and broncho-pneumonia a few days later. Window-cannula inserted in trachea. Treatment with constant alkaline vapors. Recovery.

1307**Removal of Foreign Bodies from Bronchi and Esophagus by the Aid of the Fluorescent Screen.**

W. FREUDENTHAL, *Berl. Klin. Wchnschr.*, Aug. 15, 1910.

Report of three cases of the removal of foreign bodies by this method. F. believes that in the majority of cases of foreign bodies a diagnosis can most easily be made by this means which is far more simple than direct bronchoscopy.

1308**Bronchoscopic Aid in Thoracotomy.**

O. C. GAUB.

Original contribution to *THE LARYNGOSCOPE*, p. 150, Feb., 1910.

1315**Method of Respiration by Intratracheal Insufflation.**

S. J. MELTZER, *Med. Rec.*, March 19, 1910, and *Berl. Klin. Wchnschr.*, March 21, 1910.

Meltzer says that when through an opening in the trachea a tube, of a diameter which is distinctly smaller than the lumen of the trachea, is introduced so as to have the lower end reach the bifurcation, or resting loosely even within the upper end of one bronchus, a stream of plain air, sent continuously through this tube, will keep up the life of even a completely curarized animal.—*Ex.*

1323**Unusual Foreign Body in Right Bronchus Removed by Lower Bronchoscopy.**

C. W. RICHARDSON.

Original contribution to *THE LARYNGOSCOPE*, p. 988, Oct., 1910.

1324**Bronchial Vincent's Angina.**

J. H. ROTHWELL, *Jour. A. M. A.*, June 24, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 889, Sept., 1910.

1331**Removal of a Pin from a Bronchus.**

THOMSON, *Lancet*, May 7, 1910.

Thomson reports the case of a young woman, who, while dressing, held a shawl pin between her teeth which vanished down her throat as she

opened her mouth in laughing. X-ray examination showed the pin lying about one and a half inches below and slightly internal to the right nipple, with the head downward and moving freely upward and outward with each respiration. The pin was successfully removed.—*Ex.*

1333

Simple Method by which an Open Safety-Pin was Removed from the Bronchus without Closing the Pin.

O. W. TURNER.

Original contribution to THE LARYNGOSCOPE, p. 1129, Dec., 1910.

1334

Foreign Body in the Right Bronchus.

VIGNARD and SARGNON, *Lyon Med.*, Feb. 6, 1910.

Boy, aged 4 years, aspirated the mouth-piece of a whistle. No immediate or delayed ill effects. Upon a deep inspiration a whistling sound could be heard. Radioscopy and positive radiography.

1337

Foreign Body Removed from the Bronchus.

S. YANKAUER.

Original contribution to THE LARYNGOSCOPE, p. 1049, Nov., 1910.

1338

Osteoplastic Tracheopathy.

L. ASCHOFF, *Trans. German Pathol. Soc.*, p. 125, 1910.

According to the experiments of Brückmann, Aschoff's pupil, multiple exostoses and echondromata of the cartilage of the trachea are symptoms of a peculiar disease affecting either the outer or inner longitudinal cords. Cartilaginous involvement is secondary. Aschoff relieved this condition in two cases. He holds that the changes designated by him as "tracheopathia osteoplastica" are not the result of an inflammation but a malformation of the elastic ligaments.

1345

Tuberculous Disease of the Trachea Leading to Cartilage Necrosis.

T. GUTHRIE, *Jour. of Laryngol., Rhinol. and Otol.*, May, 1910.

Guthrie reports a case of tuberculous disease of the trachea leading to cartilage necrosis and involvement of the thyroid gland. A man, aged forty years, with pulmonary tuberculosis, left a sanatorium within two months after entrance without further physical signs of disease, and with entire absence of bacilli. There was slight respiratory stridor, apparently due to a mass in the anterior portion of the trachea about an inch below the glottis. Tracheotomy was performed under local anesthesia, and on exposure of the isthmus of the thyroid gland it was found infiltrated with new growth. Division of the isthmus revealed erosion of portions of the first and second tracheal rings at this point, whence an opening led through a mass of growth into the lumen of the upper end of the trachea. Masses removed from both these situations showed marked tuberculous changes. A few days later the tuberculous masses were removed after splitting the larynx, all surfaces were scraped and

rubbed with pure lactic acid, and the lumen was then packed with iodoform gauze down to the level of the tracheotomy tube. The patient did well, and when last seen, some six months before this report, there was no evidence of the return of the tracheal disease.—*Ex.*

1346

Shawl-pin in the Trachea Removed per via natural.

T. HALT, *Ugeschr. f. Læger*, p. 1132, 1910.

The patient went for two days with a shawl-pin 6.2 cm. long in the trachea without any inconvenience. KIAER.

1348

Asphyxia Caused by Lumbricoid *Ascaris* in Trachea.

HAUSTED, *Hospitalstidende*, No. 20, 1910.

In a child, aged 3 years, who was suffocating, tracheotomy was performed, whereby a female *ascaris*, 17 cm. long was found.

1353

Some of My Mishaps in Seventy-five Cases of Tracheo-Bronchoscopy and Esophagoscopy.

S. LARGE.

Original contribution to THE LARYNGOSCOPE, p. 1050, Nov., 1910.

1355

Anesthesia by Intracheal Insufflation.

H. LILIENTHAL, *Ann. of Surg.*, July, 1910.

The most remarkable feature of the anesthesia in this case was the total disappearance of the noisy rattling respiration which existed during the administration of the ether by the usual method. Lillenthal considers that this case was a most severe test of the Meltzer method of anesthesia, because of the foul and septic condition of the discharge from the pulmonary cavity. In spite of this there was no pneumonia, not even a bronchitis.—*Ex.*

1356

Kuhn's Peroral Intubation.

L. MAHLER, *Hospitalstidende*, p. 305, 1910.

Mahler has used this method in twenty-five cases with excellent result. KIAER.

1358

Case of Tracheal Scleroma in a Young Man.

F. PICK, *Wr. Klin. Wchnschr.*, No. 1, 1910.

Inoculation with a rhino-scleroma bacilli preparation according to Pirquet's method. Negative results.

1362*Nineteen Foreign Bodies Removed from the Air-Passages by Tracheo-Bronchoscopy.**

A. DEL RIO, *Ztsch. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 62, Heft 1, 1910.

Nineteen cases of foreign body in the upper air passages are reported of which nine were lodged in the trachea, three in the right bronchus, four in the left bronchus and one at the bronchial bifurcation.

Of the character of the foreign bodies: seven were glass-headed pins, one, a lead pencil, eight watermelon seeds, two, beans and one a plant seed.

Of the nineteen cases: seventeen were safely extracted by tracheo-bronchoscopy; two died.

GOLDSTEIN.

1372**Case of Esophageal Stricture Treated by Sling-Shot of Various Sizes with Excellent Results.**

C. W. ALLEN, *New Orleans Med. and Surg. Jour.*, Jan., 1910.

Two fine bird-shots were perforated and fastened on one end of a stout piece of silk. The patient was requested to swallow this, keeping hold of the other end of the string. By drinking a sip of water and waiting some time, it was felt to slip through beyond the stricture. Then with a little steady traction upon the string they were pulled back again. This was continued several days and two slightly larger shot were substituted and the process continued. The size of the shot was gradually increased until now he swallows without difficulty a lump of lead as large as a pecan.

The patient, 19 years old, at the age of four years, swallowed concentrated lye which resulted in difficulty in swallowing until he could take only liquids and in very small quantities. Since the treatment he has been taking solid food, resulting in rapid gain in weight.

In selecting cases for this plan of treatment it is necessary that at least liquids in small quantities can pass the stricture and the patient must be sufficiently old or intelligent to co-operate.

SCHEPPEGRELL.

1374**Removal of Whistle from Esophagus After Five Weeks.**

F. K. BOLAND and R. B. RIDLEY, *Charlotte Med. Jour.*, March, 1910.

Child, ten years old. For an hour after swallowing the whistle he choked desperately and for a week he vomited frequently upon eating. After that there was but slight deglutitive and respiratory difficulty.

The border of the left sterno-mastoid muscle was incised from the level of the upper border of the thyroid cartilage downward. A bougie was passed through the mouth and used as a guide in cutting. The whistle was very far down and was removed with a forceps. For a week the patient was fed almost entirely by rectum. Patient recovered.

1377**Case of Foreign Body in the Esophagus with Fatal Termination.**

C. M. BOURACK, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, May-June, 1910.

At first it was believed that a fish-bone had lodged in the esophagus. Bourack, however, determined, by means of von Eicken's pharyngoscope that no foreign body was present, but that the larynx was injured, apparently from the many unsuccessful attempts to dislodge the body. Five days later phlegmon developed in the larynx so that a tracheotomy was made and the abscess opened. Two days later he died of mediastinitis. At autopsy no foreign body could be found.

1382**Study of Foreign Bodies in the Esophagus and Bronchus.**

R. CLAQUE, *Gaz. hebdomadaire des Sciences Médicales de Bordeaux*, March 20, 1910.

The author presents one case of foreign body in the bronchus and two cases of foreign bodies in the esophagus.

Case 1. A child of 6 years aspirated a pine-cone. Tracheotomy and inferior bronchoscopy. Removal. In such cases superior bronchoscopy, in provoking cough, causes the foreign body to obstruct the larynx and is not indicated.

Case 2. Child of 8 years swallowed a sou. Positive radiology. Foreign body at the entrance of thorax. Removal by esophagoscopy.

Case 3. Child of 4 years swallowed a metallic toy of 25 mm. length. He was seen sixteen days later. Positive radiology showed the object above the aortic isthmus. Esophagoscopic removal.

1384**Contribution to the Question of Left Recurrent Paralysis Following Mitral Stenosis.**

G. COHN, *Arch. f. Laryngol. u. Rhinol.*, Bd. 24, Heft 1, 1910.

C. reports an unusual case of mitral stenosis, with dilatation of the left auricle, the diagnosis being substantiated by a very clear radiogram. He concludes that the recurrent nerve may be paralyzed: 1. Following direct pressure by a largely dilated left auricle. 2. Following indirect pressure of the pulmonary artery on the recurrent with dilatation of the left auricle. 3. Abnormal course of the ductus Botalli.

GOLDSTEIN.

1386**Routine Examination of the Esophagus.**

C. M. COOPER, *Am. Jour. Med. Sci.*, Feb., 1910.

Cooper says the technic of the examination of the esophagus is as follows: The stomach should be empty, and the esophagus, if dilated, should be washed out. No sound should have been passed for at least twenty-four hours. An injection of one-fourth grain of morphine and one-hundred grain of atropine is given half an hour previously. The structures of the throat are well anesthetized with ten per cent solution of beta-eucaine with adrenalin. The patient may be examined in the sitting, left lateral, or dorsal position. Cooper prefers, when possible,

to have the patient seated on a cushion on the floor. The back and feet are placed against firm supports; another cushion is put under the knees. An assistant supports the head, which is dorsally flexed. The patient is told to breathe quietly; to swallow when told to do so; to raise his hand if in pain, since he cannot speak; and to pay no attention to drooling saliva. He uses the Einhorn instrument, which carries its own light, and watches its passage over the back of the tongue past the epiglottis into the pharyngeal slit. The mandrin is then introduced and the instrument is carried past the inferior constrictor. The mandrin is then withdrawn and the further progress of the instrument watched. The previous investigation will have told us what bore instrument can be used and the length of instrument to be chosen. It is carried to the site of the lesion. The appearance of the lesion is in many instances quite characteristic, the wrinkled sac of a diverticulum, the rosette-like appearance occasioned by a local spasm, the bleeding ulcerated nodules of a carcinoma if seen are readily recognized. In other instances the picture presented by extraesophageal growths is exactly similar to that seen in some cases of carcinoma.—*Ex.*

1390

Case of Foreign Body in the Esophagus.

A. DOS SANTOS, *Rev. hebd. de Laryngol., d'Otol. et de Rhinol.*, Feb. 5, 1910.

Part of dental plate removed from esophagus by esophagotomy. A schematic radiogram accompanies the text.

1391

Operative Removal of False Teeth From the Esophagus.

H. H. DREESMANN, *Med. Klinik*, Oct. 16, 1910.

In both cases it was impossible to locate the foreign body by means of esophagoscopy. In the second case the dental plate remained three-fourths of a year in the esophagus. It was finally located by radioscopy and removed by external esophagostomy. Recovery.

1400

Saliva Sign of Cancer of the Esophagus.

R. GAULTIER, *Jour. A. M. A.*, Feb. 26, 1910.

Report of a case in which the so-called Roger-esophago-salivary symptom was present, a continual sialagogue. This symptom is described in twenty cases in medical literature. In some cases the salivary symptom preceded all other appearance of the carcinoma. Because of his investigation on dogs, the author substantiates Roger's hypothesis that this symptom is the result of an irritation of the mucous membrane of the esophagus.

1401

Foreign Bodies in the Esophagus and Esophagoscopy.

R. GEZES, *Rev. hebd. de Laryngol., d'Otol. et de Rhinol.*, Aug. 6, 1910.

Diagnosis and removal of foreign bodies by means of the X-rays.

1402**Etiology of Congenital Atresia of the Esophagus with Tracheo-Esophageal Fistula.**

GIFFHORN, *Virchow's Arch.*, Bd. 192, Heft 1, 1910.

The author describes two cases of congenital atresia of the esophagus with tracheal fistula in the bifurcation cavity, due, most likely, to the fact that the ligament which ought to separate the esophagus and trachea have become united to the posterior wall of the anterior intestine in a certain stage of their development. Thus the occlusion of the upper esophagus and the esophago-tracheal fistula takes place. In those cases in which there is an extensive communication between the lower portion of the esophagus and the trachea, he thinks it possible to insert the separating ligaments at the posterior wall of the anterior intestine instead of, as usual, at the anterior wall.

1404**Structure of the Mammalian Esophagus.**

E. GOETSCH, *Am. Jour. of Anatomy*, Jan., 1910.

In reference to the occurrence of gland in the esophagus, the author distinguishes between three groups: Mammals in whom the level of the ring-cartilage of the esophagus was entirely absent; mammals in whom there are few glands; and a small group in whom a profuse number are present.

1406**Abnormal Types of Cicatricial Stricture.**

GUISEZ, *Bull. de Laryngol., Otol. et Rhinol.*, April 1, 1910.

Guisez compares his observation of ten cases of cicatricial stricture. He points out the long interval of time often elapsing between the cause of the stricture and the stricture itself—in one case thirteen years and in another fifty years. This makes the diagnosis harder, especially in older people where one often suspects a neoplasm.

1413**Syphilis of the Esophagus.**

GUISEZ and ABRAND, *Progress Med.*, March 5, 1910.

Author reports several cases of syphilis of the esophagus and points out the value of esophagoscopy in the diagnosis of the disease. Secondary symptoms, as erosions, are present; but the most frequent symptoms are gummata and stenosis.

1415**Foreign Body in the Esophagus and Lower Air Passages.**

P. M. HICKEY, *Jour. Mich. State Med. Soc.*, Jan., 1910.

Report of seven cases of foreign body in the esophagus, six coins and one button. One patient died of bronchopneumonia after attempts at removal. In another case the esophagus was exposed by an external incision and the coin pushed into the stomach by external manipulations. In two cases the coins were removed by esophagoscopy. In one case dyspnea occurred forty-eight hours after successful removal, which necessitated intubation.

1419**Esophagoscopic Removal of Open Safety-Pins by a New Method.**

C. JACKSON.

Original contribution to THE LARYNGOSCOPE, p. 446, April, 1910.

1426**Dental Plate in Esophagus.**LAVRAND and d'HALLUIN, *Jour. des Sci. Med. de Lille*, June 18, 1910.

Case of woman, aged 55. Radioscopic examination showed the plate at the second D. V. Bronchoscopic removal with the aid of the X-rays attempted, but not successful. The next day esophagoscopy, under control of the X-rays, but likewise unsuccessful. Three days later removal by external esophagoscopy, but the patient died within forty-eight hours.

The author strongly recommends esophagoscopic removal in such cases, with the aid of the X-rays, and feel that esophageal spasms the only cause of failure may be overcome by means of a more complete cocaineization.

1430**Three Cases of External Esophagoscopy for Removal of Set of False Teeth.**MANDEL, *Muench. Med. Wchnschr.*, March 1, 1910.

Half of an upper set of teeth was swallowed and removed by external esophagoscopy. Complete recovery. A detailed history of the case is given.

1432**Esophageal Diverticula.**E. MAYER, *Med. Rec.*, July 2, 1910, and *Arch. Internat. de Laryngol. d'Otol. et de Rhinol.*, July-Aug., 1910.

Mayer says that in esophageal diverticula examinations should be conducted in a routine manner, the esophagoscope being used fast, bearing in mind always the danger of a rupture of a possible aneurysm. In making the examination with the X-ray, the introduction of a soft tube filled with shot may take the place of bismuth. As to treatment, Mayer says that where the diverticulum has not occasioned any symptoms beyond that of mild distress, we may content ourselves with occasional washing out of the diverticulum and care as to diet. Where, however, emaciation exists, the diagnosis having been firmly established radical operation may be performed with success. Whether a previous gastrostomy should be done or not, must be decided for the individual case, but enough information is at hand to show that the operation for pharyngo-esophageal diverticulum is readily performed and reasonably safe. Stetten has collected statistics of sixty radically operated cases; of these fifty patients were cured and ten died.—*Ex.*

1436**Expulsion in Tubelike Form of the Mucous Membrane of the Esophagus in the Course of a Case of Hydro-Chloric Acid Poisoning.**

E. NEISSER, *Berl. Klin. Wchnschr.*, Jan. 3, 1910.

Neisser reports a case in which a man 35 years old, drank some hydrochloric acid with suicidal intent. Brownish masses of blood were vomited and the mucous membrane of the lips, mouth, and throat were badly burned. He was unable to swallow. On the ninth day he expelled from his mouth a tubelike cast of his esophagus, thirty cm. long. It was frayed at the lower end, had a large defect in one wall, and had brownish bloody cords on its inner surface. After this had been expectorated the patient felt easier, and on the next day was able to swallow.

1447**Traumatic Esophageal Stricture.**

G. W. ROSS, *N. Y. State Jour. of Med.*, July, 1910.

The stricture in this case followed the drinking of water from a tin can which had contained lye. The stricture was located by means of the Roentgen ray, and was dilated by means of bougies. The patient was only 2 years old.—*Ex.*

1452**Bone in the Esophagus.**

G. STRAZZA, *Arch. Ital. di Laringol.*, July, 1910.

Report of two cases, one of a woman of 35 years, the other, one of 28 years. In both cases the foreign body was successfully removed though external esophagoscopy had to be resorted to in one case.

1462**Foreign Bodies in the Esophagus and their Treatment.**

V. UCHERMANN, *Norsk Mag. f. Laegevidensk.*, Dec., 1910.

Uchermann discusses the lessons learned from his personal experience. He points out the need of examining the opposite side of the esophagus, from which infection may occur. The Roentgen examination should always be made by an expert, as fatalities have resulted from perforations made in attempts at removal, remote from the actual site of the foreign body.

1466**Fatal Esophageal Hemorrhage Eight Days After Swallowing Foreign Body.**

P. G. WALLER, *Albany Med. Ann.*, Jan., 1910.

At the autopsy two linear ulcers were found in the esophagus, one communicated with the aorta. The foreign body—a bone—was not found.

1468**Surgical Treatment of Tuberculosis of the Larynx.**

W. ALBRECHT, *Ztschr. f. Ohrenh. u. f. die Krankh. der Luftw.*, Bd. 61, Heft. 2, 1910.

After numerous experiments on animals and the human the author comes to the following conclusions: Removal of the diseased tissues

with a curette has produced a cure only in exceptional cases. Galvano-cautery, on the other hand, affects even the regions bordering on the diseased parts and destroys infiltrations which may have remained. Too severe inflammations and edema are preventable by regulation of current. If this does not suffice radical cauterization is indicated.

1471

Operative Treatment of Severe Cases of Thickening of the Vocal Cords.

E. BAUMGARTEN, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Heft 2, 1910.

Report of three cases successfully operated by carefully removing the thickened mucosa. The first case was concomitant with a hematoma resulting from strain; the second was due to irritation caused by papillomata; and the third, which embraced both cords, was lymphectasia.

1472

Electro-Cautery Treatment of Tuberculosis of the Larynx in the Oto-Laryngological Clinic in Basle.

W. BENN, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61, Heft 2, 1910.

The cautery is used, in connection with the double-curette, to burn away at one sitting all diseased tissue, infiltrated and ulcerated. The smoke is blown out with water-spouts. The result is apparently a very favorable one, but the procedure is more favorably adapted to a hospital because of complications such as laryngeal edema and emphysema of the skin. The author warns against the use of the electro-cautery, however, where pronounced pulmonary involvement is present.

1473

Hemi-Laryngectomy for Epithelioma; Exhibition of the Patient.

T. P. BERENS.

Original contribution to *THE LARYNGOSCOPE*, p. 984, Oct., 1910.

1475

New Simplified Technic for Esophageal Explorations.

E. BOTELLA, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, Jan.-Feb., 1910.

The author criticises the present positions in which the patient is placed for esophagoscopy and recommends one half-way between the Rose and a sitting posture. The patient is placed on a low armchair whose back may be lowered 120°, by means of a cushion the seat is raised or lowered. The neck of the patient rests comfortably in the rounded top of the back of the chair. The operator stands or sits in back of the patient. He uses a Kirstein spatula in his left hand and introduces the esophagoscope with his right hand. The advantages consist in the additional comfort for the patient, the uselessness of an assistant, ease of manipulation both in the hospital and in the office without anesthesia, and the possibility of working throughout with direct vision. It has, however, the disadvantage that the other methods have, namely that secretions accumulate at the bottom of the instrument, during esophagoscopy, which must be removed by some means.

1476**Some Modifications in the Technic of Total Laryngectomy.**

E. BOTELLA, *Bol. de Laringol, Otol. y Rinol.*, Nov.-Dec., 1910.

The author prefaces his article with a resume of the histology of laryngectomy. He continues with a description of the various methods in vogue—that of Perlier, Gluck, Le Bec and Real, the latter operation being performed in two stages each of which is described. B. then points out in how far these methods fail and describes his own technic.

1477**Laryngoscopy in Cancer of the Larynx.**

R. BOTEX, *Rev. Ibero. Am. de Cien. Med.*, April, 1910, and *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, May-June, 1910.

Laryngostomy can be advantageously employed in cancer of the larynx, according to the author, unless the simple operation does not suffice and total resection is necessitated. Whether laryngostomy has a future in the treatment of malignant tumors of the larynx is still an open question, and the most conservative method—the Italian—should be employed so as not to hasten recurrence through irritation.

1482**Experimental and Critical Investigations Upon the Effect of the Sun, the Roentgen-Rays and Mercury Vapor Tubes on Laryngeal Tuberculosis in Rabbits.**

BRUENINGS and W. ALBRECHT, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 60, Hefte 3 u. 4, 1910.

Since laryngeal tuberculosis in rabbits runs the same histological course as that in man, the author tested the treatment on these animals. They came to the conclusion that treating laryngeal tuberculosis with the short concentrated and cooled spectral light waves as well as with the mercury vapor tubes was unsatisfactory both clinically and histologically. On the other hand properly regulated treatment with the Roentgen rays gave entirely successful results.

1483**Radium-Therapy in Cicatricial Stenoses of the Laryngo-Tracheal Duct.**

CANTAS, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, May-June, 1910 and *Lyon Chir.*, July, 1910.

Cantas gives a theoretic opinion on radium-therapy, pointing out the possible advantages. If intubation be impossible and the lumen be almost entirely destroyed, it should follow laryngotomy. If intubation be possible, radium-therapy may be used in conjunction with it, and may take the place of the operation.

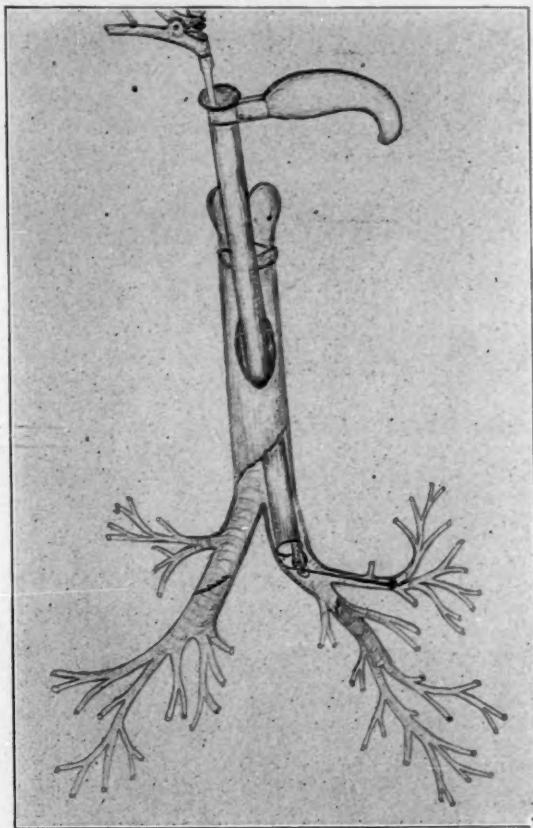
1485**The Cutting in Two of a Large Steel Pin While Transfixed in the Left Bronchus and its Removal by Lower Bronchoscopy.**

W. E. CASSELBERRY, *Jour. A. M. A.*, July 2, 1910.

A glass-headed, one and one-half inch, very sharp, black, steel pin, cut was found by upper bronchoscopy to be immovably transfixed in the

first bronchial branch and across the left bronchus of a 15 year old girl, and the manner in which this accident happened should be made generally known in order that so dangerous a method of dressing may be avoided.

The young woman, with pin in mouth and skirt in hand, in readiness to drop the skirt over her head, raised very high her out-stretched

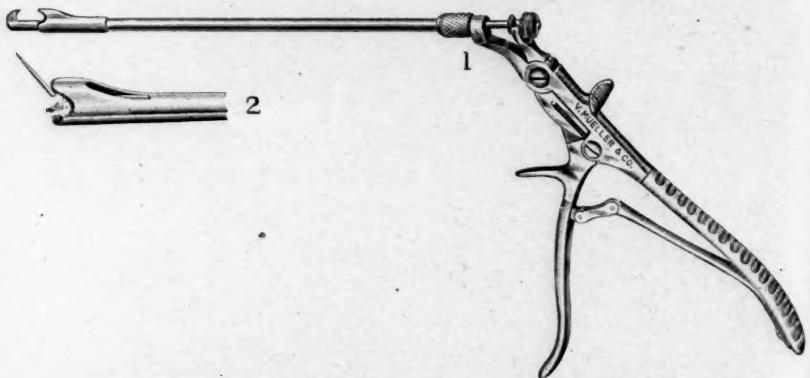


arms,—an act which is identical with the first movement in Sylvester's method of artificial respiration, which owes its power to the fact that raising the arms, expands the lungs and causes an inrush of air, the mouth opening, itself, as if by instinct; and, at the same moment, to let the skirt fall clear of her hair, the head was thrown backward and face upward, bringing the mouth, larynx and windpipe into a straight vertical line, an attitude identical with the sword-swallower's position. The

pin, let loose, simply dropped with the air current head foremost into the left main bronchus, and on downward till its head and two-thirds of its stem had passed into the first bronchial branch, where, being too long to quite make the turn, it was arrested, with its head compressed against an upturning segment of the bronchial branch, and its point against the opposite wall of the main bronchus. Both ends of the pin being against a barrier, the impact of cough had sufficed to drive its point firmly into the bronchial wall and in this transfixed position it had remained, without causing serious discomfort for ten weeks. Freedom



from suffering for so long a period leads a patient to forget or to doubt the presence of a foreign body and as the physical signs are indefinite when the object is but slightly obstructive, the X-ray supplemented by bronchoscopic inspection may be the only means of positive demonstration. That the X-ray, however, has its shortcomings and really needs to be supplemented by direct observation through the bronchoscopic tube was made evident by a serious delusion in the interpretation of the first skygraph of this case, an extraneous or false shadow, "very like a pin"



which appeared on the right side having been at first accepted, as the sought-for outline whereas, the pin was lodged on the other side, its real shadow obscured in the shade of the sixth rib. Furthermore, nothing short of upper bronchoscopy could have disclosed the exact position and state of transfixion of this pointed object, a disclosure essential to devising a plan for its removal. At this first operation every effort was made through the bronchoscopic tube to displace the pin without cutting it. It was grasped at the depth of eleven inches, with various bronchoscopic forceps, the grasp being many times renewed to change forceps or van-

tage point of the grip, but without avail, except for the conviction, that it must first be cut in two.

Based on the favorable result of the following procedure it is proposed, as a general principle, in order to facilitate the bronchoscopic extraction of immovably transfixated pointed objects, such as pins, needles and perhaps open safety pins, first, to divide them, through the bronchoscopic tube, into two or more parts; and the instrument or pin-cutter, devised for this purpose is described.

A valid criticism, would seem to be the disposition of the parts of a pin, when cut, to fly asunder hence, possibly, to drop out of sight or out of reach of the bronchoscopic forceps. But this contingency did not occur, for the beak-shaped, slotted scissor-like cutting mechanism is so devised that one of the two fragments will adhere with dependable regularity and firmness in the serrated slit alongside the blade bevel, as long as the blades are not permitted to reopen, and moreover, the operator can elect the fragment to be so held by turning the blade. Therefore it was planned to minimize the major risk of losing the smaller fragment by electing it to be held in the grasp of the pin-cutter.

It was deemed expedient by reason of the novelty of the procedure to operate this time by lower bronchoscopy although it is now realized that the pin-cutter and the principle of its use are applicable as well at the longer range of upper bronchoscopy. A few additional efforts to extract the pin without cutting having proven futile, the pin-cutter was passed down the bronchoscopic tube. It operated exactly as planned, one could hear the snap, see the larger fragment shiver and then discern the small pointed piece in the beak of the instrument, held fast in which it was withdrawn, and in another minute, the larger piece, in the grip of the bronchoscopic forceps, came safely out.

A. A.

1486

Intubation and Tracheotomy for Acute Laryngeal Stenosis in Children.

CITELLI, *Boll. delle Mal. dell 'Orecchio, della Gola e del Naso*, July, 1910, and *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzgeb.*, Bd. 3, Heft 3, 1910.

The author belongs to neither of the two groups of those who advocate exclusively either intubation or tracheotomy. It is his practice when called to see a child suffering from dangerous acute laryngeal obstruction to proceed at once to intubation. If the child can be kept under constant observation and the tube lies well in position it is allowed to remain for twenty-four hours, after which it is removed. If the obstruction then returns the tube is replaced for another twenty-four hours. If, however, on removal at the end of that time the obstruction again returns, the tube is replaced, but a tracheotomy is at once performed, and is, of course, much simplified by the presence of the intubation tube. The latter is then permanently removed, and only employed later if constant dilatation of the laryngeal lumen is required, in which case its lower end is fixed to the tracheotomy tube.

The essential point of the method consists in the combination of intubation and tracheotomy with the object of diminishing the not in-

considerable number of chronic stenoses which follow the employment of either procedure. While admitting that the method entails the performance of a certain number of tracheotomies that might have been avoided, the author claims for it the great advantage that it prevents a considerable number of chronic laryngeal stenoses, which are undoubtedly due to irritation of the inflamed mucous membrane by the intubation tube.

GUTHRIE.

1487**Treatment of Laryngeal Tuberculosis in Public Sanatoriums.**H. CLARUS, *Beitr. zur Klin. der Tuberkulose*, Bd. 15, No. 2, 1910.

In his sanatorium in Goerbersdorf, Clarus employs light-ray therapy, medicaments and operative treatment. The ideal—complete laryngeal rest—is difficult to obtain in sanatoriums.

1488**Temporary Tracheotomy for Foreign Bodies in the Trachea or Bronchi.**COLLET, *Lyon Med.*, Oct. 9, 1910.

Report of five cases in which tracheotomy was employed. The author claims the following advantages for this method: (1) It facilitates hemostasis, because of the tracheo-cutaneous suture, (2) tracheal exploration is more readily accomplished and (3) respiration is greatly aided.

1491**Radical Operation for Carcinoma of the Larynx and Epiglottis with Primary Suture of the Esophagus.**J. DOLLINGER, *Orvosi Hetilap*, No. 13, 1910.

The operation may be performed under local anesthesia. The epiglottis was transformed into a tumor, the size of a small apple which ended at the cricoid cartilage. The esophageal wound was immediately closed. The author does not recommend the use of a tube in the esophagus as it may cause decubitus.

1496**Technic of Upper Bronchoscopy.**A. EPHRAIM, *Arch. f. Laryngol. u. Rhinol.*, Vol. 23, Heft 1, 1910.

Ephraim insists on the employment of an anesthetic before intubation. For this purpose he paints the larynx with twenty per cent alypin and for the trachea, a warm ten per cent novocain solution is used.

1497**Technic of Tracheo-Bronchoscopy.**

G. FERRERI.

Original contribution to THE LARYNGOSCOPE, p. 434, April, 1910.

1499**Electro-Mechanical Treatment of Vocal Disturbances.**T. S. FLATAU, *Die Stimme*, Oct., 1910.

Treatment is carried out by means of a one-fourth L. p.—electric motor with rheostat speed control by which compressed air is supplied in vary-

ing pressures; this air passes through a rotary siren and from the siren by flexible tubing to a pair of hollow cups which are fastened in position, one on each side over the thyroid cartilage. The feature of this penumo-phono-vibration is that the vibrations per minute are selected to correspond to the vocal tone sustained by the patient during this vibratory treatment. The author claims remarkably satisfactory results from this treatment not obtainable by simple mechanical vibration.

GOLDSTEIN.

1501

New Method of Treating Functional Vocal Disturbances with Remarks on Their Pathology and Therapy.

T. S. FLATAU, *Berl. klin. Wchnschr.*, July 4, 1910.

Functional vocal disturbances are not always equivalent to anatomical disturbances, which are often vainly sought for in the former conditions. To combat the functional disorders the author has invented a new compressed air apparatus. Besides this the author demonstrated:

1. A laryngeal stethoscope by which the accessory sounds which accompany the voice may be heard;
2. An instrument for illuminating the larynx; and
3. a combination of this instrument with a laryngeal stroboscope.

1502

Transverse Tracheotomy.

O. FRANCK, *Muench. med. Wchnschr.*, No. 6, 1910.

Franck puts forward a strong plea for a transverse skin and tracheal incision. A transverse incision of about one and three-quarter inches is made over the cricoid cartilage, the skin being pinched up before being incised so as to avoid dividing the anterior jugular veins which are not raised with the skin. The head is bent backwards, and the wound gapes, especially downwards, giving a clear view of the subjacent structures. The muscles are separated mesially in the usual way. The isthmus of the thyroid gland is gently pressed down by the left index finger, and the trachea opened transversely; the tracheal wound gapes, the tube is inserted, and the skin wound stitched at both ends.

The following are the advantages claimed for this method:—The cosmetic result is greatly superior to that of the longitudinal incision, as the scar lies in the fold of the neck, the incision being one of Kocher's "normal incisions." The stitched-up parts of the skin almost invariably heal by first intention, as the secretion which is expelled from the tube does not run over them, while aseptic healing is exceptional in the longitudinal method. The exact situation of the mesial intermuscular division may be missed in the case of the longitudinal incision, but the transverse lays open the whole field. The transverse opening in the trachea obviates the difficulty of introducing the tube, for if the head be bent backwards, the tracheal wound is opened widely, and the tube is easily slipped in without the use of any instrument. When the tube is removed the tracheal rings, when the head is in normal position, fall

back into place with almost mathematical accuracy. Stenosis of the trachea is much less apt to occur as a late result of the operation. The transverse operation requires no retractors, nor any instruments except a knife and the tracheotomy tube.—*Ex.*

1504

Case of Total Laryngectomy for Cancer of the Larynx.

GAULT, *Arch. internat. de Laryngol. d'Otol. et de Rhinol.*, Jan.-Feb., 1910.

Bronchitis with purulent sputum does not contra-indicate operative interference, especially if the operation be performed in two stages. To feed the patient, he recommends the intranasal use of the Nelaton catheter. The fact that the esophagus remains open is no serious complication.

1505

Intubation for Small Foreign Bodies in Air Passages of Young Children.

M. GIOSEFFI, *Gaz. degli Osped. e delle Clin.*, Sept. 6, 1910.

If the foreign body is small, free or not firmly lodged, it is probable that it will be spontaneously expelled after intubation. The author does not base his assertion on personal experience, but on that of others.

1506

Treatment of Severe Laryngitis Complicating Measles in Children.

A. GIRARD, *These de Paris*, 1910.

In measles there is always a slight catarrhal laryngitis and hoarseness. This complication is often erythematous and is accompanied by dyspnea. It may result in a true stridulous laryngitis. The symptoms are similar to diphtheritic laryngitis. In severe cases the author advises intubation.

1507

Cordectomy for Bilateral Abductor Paralysis with Demonstration of Specimen.

J. GLEITSMANN.

Original contribution to *THE LARYNGOSCOPE*, p. 451, April, 1910.

1508

Treatment of the Dysphagia of Laryngeal Tuberculosis by Alcohol Injections into the Superior Laryngeal Nerve.

J. D. GRANT, *Lancet*, June 25, 1910.

The patient a young woman aged 24, could not take nourishment except in the form of thin liquids owing to the extreme pain in swallowing. There was no doubt about tubercular mischief in the lungs, and the history dated back for two years. The ordinary methods to relieve pain, such as the auto-inhalation of anesthesin and orthoform by means of Leduc's tube, was tried without relief. Infiltration of the left ary-epiglottic fold accompanied superficial ulceration.

Dr. Dundas Grant states that the needle was somewhat coarse in structure, and sharpened to a much more obtuse angle than in ordinary hypodermic syringes so as to render it incapable of puncturing the superior laryngeal artery, and it had a mark to indicate the depth of one and a half cm. On the night of the injection her swallowing was already

easier, and when seen three days later she stated that she could swallow quite well and thought her voice was rather better. When introducing the syringe the operator could produce pain by pressing on a particular spot, which no doubt corresponded to the site where the superior laryngeal nerve penetrated the thyrohyoid membrane. He introduced the needle and felt about until it touched a spot which sent a pain shooting up to the ear, then he injected gradually eighty per cent of spirit. He had not been tempted to do the excision of the nerve mentioned by Mr. Clayton Fox, as it was much more serious than injection. The duration of relief varied, but sometimes it was weeks or months. The present patient was injected only twelve days ago, but he had a patient in Brompton Hospital who was injected a month ago and the relief still lasted. That was borne out by the results in the treatment of trigeminal neuralgia.—*Ex.*

1509

Remarks on X-ray Technic in the Treatment of Laryngeal Papillomata in Children.

A. L. GRAY, *Ann. of Otol. Rhinol. and Laryngol.*, June, 1910.

Report of two cases which were benefited by this method. In both cases tracheotomy had been previously performed.

1512

Three Cases of Laryngostomies for Cicatricial Crico-Tracheal Stenosis Necessitating Tracheotomy.

M. GUISEZ, *Bull. de la Soc. de Ped.*, Feb., 1910.

Chronic crico-tracheal stenoses necessitating tracheotomy. In one child, aged 14 years, who had worn a cannula since 3 years old, there was a very striking atrophy of the larynx and the laryngeal cannula was found with difficulty. The author used Sargnon's method: Laryngostomy, caoutchouc dilatation and plastic operation.

1516

Treatment of Laryngeal Tuberculosis with Galvano-Cautery.

F. HUTTER, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 5, 1910.

The author discussed the indications and contra-indications on the basis of the statistics of thirty-two cases. As an anesthetic he recommends a combination of cocaine, locally, and morphin subcutaneously.

1518

Laryngostomy in Perichondritis of the Larynx.

A. IWANOFF, *Presse Oto-Laryngol. Belge*, Jan., 1910.

The author has modified his previous technic according to Sargnon's and Barlatier's suggestions. Observations.

1527

Coin Removed by Esophagoscopy After Twenty-Seven Days.

LAVRAND, *Jour. de Sci. Med. de Lille*, June 18, 1910.

Lavrand recommends the use of the Kirrison hook for removing coins or similarly round bodies, and esophagoscopy then only when this method fails. A case is reported.

1528**Complete Removal of Larynx Under Local Anesthesia. Its Advantages.**

LAZARRAGA, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, Nov.-Dec., 1910.

A practical comparison is presented for performing laryngectomy under chloroform on the one hand and by means of local infiltration anesthesia on the other hand. The author describes minutely his experiences in four laryngectomies under general chloroform anesthesia and cites the various serious complications therefrom. Five subsequent laryngectomies were done by local infiltration anesthesia, novocaine being used in one-half per cent solution. Novocaine is the author's choice for local anesthesia because of its less toxic reaction.

GOLDSTEIN.

1529**Total Laryngectomy in Two Stages.**

LE BEC, *Trans. French Congress of Surg.*, 1910.

First stage of operation:—Transverse incision through first ring of trachea severing the latter from cricoid cartilage. Dissecting trachea freely from esophagus, bending it forward and suturing in position to muscles and skin of neck.

After an interval of about twenty days, second step of operation:—Complete dissection and removal of carcinomatous larynx. Among the special details of technic may be mentioned:—Transverse drainage tube inserted at first operation lying over arch of bent trachea to drain secretions from laryngeal areas, feeding of patient by means of rubber tube introduced through nose into esophagus; keeping patient in sitting position throughout healing process, anesthesia first by mouth, and then through rubber tube introduced into the freshly severed trachea.

GOLDSTEIN.

1532**Physical Foundation of Helio- and Photo-Therapy in Laryngeal Tuberculosis.**

A. NEPVEU, *Recueil d'Oto-Rhino-Laryngol.*, March, 1910.

The author discusses the indication for the use of this therapy, the principles which should govern the choice of the light, and the effects and dangers of this method.

1538**Surgical Treatment of Laryngo-Tracheal Stenosis.**

SARGNON and BARLATIER, *Arch. internat. de Laryngol. d'Otol. et de Rhinol.*, Jan.-Oct., 1910.

The author discusses the endo-laryngeal procedures, direct, indirect and external, and especially direct retrograde subglottic tracheoscopy, intubation and dilation by means of caoutchouc tubes.

1545**Treatment of Hysterical Aphonia.**

M. SENATOR, *Berl. klin. Wchnschr.*, July 18, 1910 and *Arch. internat. de Laryngol. d'Otol. et de Rhinol.*, July-Aug., 1910.

Senator relates that his experiences with Seifert's method of treating hysterical aphonia have not been so favorable as those reported by Sei-

fert, but still he found it successful in a number of cases in which no benefit had been obtained from other measures. The patient's head is bent far over backward or the entire upper part of the body is tilted back. In this position the patients find that they are able to speak or intone. Seifert found that he was unable to speak in a whispering tone when his head was bent over backward in this way. The upper part of the body must be completely relaxed. In the two cases refractory to this measure in Senator's experience, the aphonia was promptly cured by other measures in the first, and in the other a thickening from chronic laryngitis may have been responsible for the failure. He is inclined to explain the success of the measure in general as due to its moral influence, adding another weapon to the armamentarium at our disposal for effectually influencing hysterical aphonia. The list includes manual pressure on the larynx, electric vibration massage, improvement of the respiration, a deep breath being taken before each single sound, and training the patients to speak in a lower key, the hysterical-aphonic patients generally having had a high-keyed voice.—*Ex.*

1547

Mechanical Treatment of Stenosis of the Larynx.

THOST, *Bull. de Laryngol., Otol. et Rhinol.*, April 1, 1910.

Thost differentiates between the various stenoses, and details their developments. The author also explains his dilatation method for treating them.

1549

Anastomosis of the Inferior Laryngeal Nerve with the Descending Branch of the Hypoglossal by Nerve Suture.

D. V. NAVRATIL, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 3, 1910.

This suture was performed in four days according to Foramitti's method, with a calf artery. Microscopic examination in a dissected dog showed neurofibrils at this site.

1552

Primary Diphtheria of the Naso-Pharynx.

ARDENNE and LEGROS, *Jour. de Med. de Bordeaux*, Jan. 2, 1910.

The author reports two observations of primary diphtheria of the nasopharynx which could be diagnosed, in spite of the youth of the children, by posterior rhinoscopy. In both cases the throat was unaffected.

1555

Diphtheria.

W. D. BLACK, *St. Louis Med. Rev.*, April, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 611, June, 1910.

1556

Diagnosis of Nasal Diphtheria in Young Infants.

BLOCKMATON, *Berl. Klin. Wchnschr.*, Oct. 31, 1910.

Blockmann urges immediate examination of the nose of sick infants because of the frequency of nasal diphtheria in infancy. Often it is diagnosed as coryza until rapid loss of weight, and strength, diphtheritic

otitis media or absolute occlusion of the nasal passage occurs. The author cites several cases in which by direct inspection of the nasal passages a true diagnosis was made prior to the bacteriological examination.

1559

Discussion on the Latent Infections by the Diphtheria Bacillus and Administrative Measures Required for Dealing with Contagions.

R. M. BUCHANON, *Jour. of Laryngol., Rhinol. and Otol.*, Feb., 1910.

The greatest menace exists where the pathogenic agent shows no morbid symptoms. The author cites statistics to confirm this view. He described very minutely the diphtheritic bacillus, the different types, its virulence and persistence.

1560

Diphtheria from the Medical Standpoint.

R. J. BUNCH, *St. Louis Med. Rev.*, April, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 623, June, 1910.

1562

Practical Consideration on the Malignant Forms of Diphtheria.

A. CASSES, *These de Paris*, 1910.

Malignant diphtheria is characterized by: Circulatory, nervous, digestive and general disorders. The treatment consists of sero-therapy and the administration of adrenalin and supra-renal extract. If, however, there is albuminuria present, there should be some hesitancy in administering adrenalin.

1565

Relation of Pseudo-Diphtheria and the Diphtheria Bacillus.

P. F. CLARK, *Jour. of Infect. Dis.*, May, 1910.

Clark concludes, from his own and other people's experiments, that the pseudo-diphtheria bacillus, the bacillus Hofmann, belongs to a different species than the true Klebs-Loeffler bacillus, though both may have had a common ancestor.

1566

Diphtheria and Its Relation to the Laboratory.

F. R. COLLINS, *Atla. Jour.-Rec. of Med.*, May, 1910.

Owing to the fact that the author has had cases in which the disease has spread to the members of the family even after the tests gave a negative culture he advises making two cultures before releasing the patient.

1569

Case of Fatal Laryngo-Tracheal Diphtheria.

DELOBEL, *Rev. hebdom. de Laryngol., d'Otol. et de Rhinol.*, July 16, 1910.

Child 7 years old, was already in a dying condition when tracheotomy was performed. Through the tracheotomy wound the child coughed out a large laryngo-tracheal abscess. Then the child breathed quietly through the cannula, for about a half hour, when it was again affected

with violent choking. The cannula was removed, the trachea cleaned to search for some remaining croupous membrane which was apparently obstructing the bifurcation region, but the child died. The author regrets not having used the Guisez-tracheoscopy forceps. Such cases point to a hitherto little recognized indication for lower tracheoscopy.

1572

Active Immunization Against Diphtheria in Man.

DSERSHGOVSKY, *Russki Wratsch*, No. 22, 1910.

For eight years the author has been trying upon himself injections of antitoxin to attain immunity, in which he succeeded. His method had, however, no followers, a fact which he explains through painfulness and length of the immunization. Now according to von Boldyrew's plan, he uses a different method of immunization, namely through the nasal mucosa, which he has tried on horses, dogs and on himself without experiencing any bad effects. This method is highly recommended because of its simpleness, the long period during which it may be used, and because of the local immunity attained in the naso-pharyngeal mucosa. Active immunization may last for many years—in himself it lasted for ten years.

1576

Acute Attack of Diphtheria Simulating Naso-Pharyngeal and Pharyngeal Disease.

P. GAWRILOW, *Russ. Monatschr. f. Ohrenh.*, No. 3, 1910.

Report of a case of pharyngeal and epi-pharyngeal herpes whose external appearance was similar to that of diphtheria. Culture showed micrococcus catarrhalis Pfeifferi.

1579

Case of Chronic Diphtheria of the Larynx.

V. GUTTMANN, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, March-April, 1910.

Girl aged 18 years, had on various parts of her larynx, false membranes in which the diphtheria bacilli was found. The disease developed with only a slight fever and was extraordinarily benignant until a month later it terminated with a post-diphtheritic paralysis of the upper larynx and a suffocating crisis.

1581

Chronic Nasal Diphtheria.

P. A. HARRY, *Hospital*, July 2, 1910.

In nasal diphtheria there is always a history of persistent rhinorrhea and otalgia. Bacteriological examination reveals true Loeffler's bacilli. The rhinoscope shows enlarged turbinates. No false membranes. The etiology is obscure; the prognosis benignant except in children under three years. Serum treatment does not suffice; local treatment (alkaline solution, oxygen silver nitrate) is also necessary.

1582**About Diphtheria and Phlegmonous Angina.**

T. HELLESTROEM, *Hygeia*, p. 913, 1910.

The author warns against making a mistake between these two diseases and especially against the incision in diphtheria. KIAER.

1587**Four Cases of Diphtheritis Paralysis Treated by Sero-Therapy.**

LAFFORGUE, *Lyon Med.*, April 3, 1910.

The author reports on four cases of diphtheritic paralysis treated with serum, in which the results were very different. He thinks that this difference is due to the biochemical composition of the sera used. Rist's theory of endotoxins makes it plausible that anti-diphtheritic serum may be similar as to the effect on the angina but dissimilar as to the effect on paralysis.

1589**Diphtheria-Bacilli Carriers.**

G. H. LEMOINE, *Soc. Med. des Hop.*, Feb. 27, 1910.

Healthy individuals who have not caught diphtheria should not be isolated even though the bacilli be virulent; those ill with diphtheria must be isolated; the convalescing need not be, unless coryza or a stubborn pharyngitis be also present.

1604**Primary Streptococcus Diphtheria.**

D. H. ORGEL, *Med. Rec.*, Aug. 13, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 11, Jan., 1911.

1608**Diphtheria Bacilli.**

D. C. RAGLAND, *South Cal. Practitioner*, June, 1910.

Ragland has devised the following stain intended specially for the "small town" physician who has a microscope but no incubator. The stain is made up of methylene blue and eosin and the adult diphtheria bacillus is quickly recognized because the polar granules are stained a deep blue, while the remaining portion of the bacillus takes the eosin or pink stain, making thereby a decided contrast. The stain is composed of three solutions, the formula and technic for using which are as follows: Solution "A": Methylene blue, saturated aqueous solution, 10 parts; 10 per cent citric acid solution, 10 parts; aqua destillata, 80 parts. Solution "B": 10 per cent aqueous solution citric acid, 5 parts; methyl alcohol, 22 parts; distilled water, 73 parts. Solution "C": Eosin, saturated aqueous solution, 1 part; aqua destillata, 199 parts.

The technic is as follows: 1. Make thin smears from throat, especially from the margin of membrane or suspicious path. 2. Dry in air. 3. Fix in flame (gas or alcohol). 4. Add sufficient blue stain "A" to cover smear and allow to act 10 to 15 seconds; then shake it off but do not wash. Now apply solution "B" and allow to act for 10 to 15 seconds, then shake it off, but do not wash. Lastly add solution "C" and allow it to act for 10

to 15 seconds; then shake off excess of stain and blot dry with filter or blotting paper, mount in Canada balsam or cedar oil and examine. Diphtheria bacilli show as pink rods with a dark blue granule in either pole. All other bacilli and cocci are stained pink. This stain has been controlled by the culture method of laboratory diagnosis in over 1,000 cases.—*Ex.*

1611

Babinski's Sign in Diphtheria.

J. D. ROLLESTON, *Rev. of Neurol. and Psychiatry*, July, 1910.

Rolleston experimented on eight hundred and seventy-seven cases and found that Babinski's sign was present in a considerable number of diphtheria cases.

1616

Nasal Diphtheria.

D. ROY, *Jour. A. M. A.*, Aug. 6, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 987, Oct., 1910.

1619

Diphtheria Simulating Foreign Body in the Bronchus.

H. SCHOLS, *Ned. Tijdschr. voor Geneesk.*, Heft 1, No. 10, 1910.

Child of 2 years suffering from dyspnea but showing no pathological symptoms. After three days the child became cyanosed and had dyspnea and stridor. The right chest did not function. A diagnosis of foreign body in the right bronchus was made, and a bronchoscopy performed. The child, in a dying condition, was tracheotomized. Although no membrane was found, diphtheria was suspected, which was bacteriologically proved. After the operation the right lung functioned again. The dyspnea, however, became more intense and the child died.

1621

Laryngeal Diphtheria Experiences.

C. H. SHUTT, *Jour. A. M. A.*, Feb. 5, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 910, Sept., 1910.

1629

Mistaken Diphtheria of Infancy.

TERRIEN, *Med. Practique*, July 26, 1910.

The value of serum treatment in diphtheria is best demonstrated when the antitoxin's used early, and consequently it is always important to discover diphtheria at its very inception. This is quite readily done, nowadays, when the diphtheritic process is localized in the typical regions. Terrien refers to the involvement of adenoid vegetations in the pharynx in the diphtheritic process. The following symptoms were noted: There was a marked coryza, with a profuse discharge which gradually soon became sanious, streaked with blood; there followed symptoms of croup and of diphtheritic bronchitis, with progressive and continuous dyspnea. In addition, there was interference with nasal respiration, hoarseness, pain in the ear, swelling of the glands in the neck, a rapid pulse, and great prostration. In the presence of such symptoms, diphtheria should be suspected, cultures taken from the pharynx and the nose, and if possible, rhinoscopy performed.—*Ex.*

1631**Diphtheria from the Neurological Standpoint.**H. UNTERBERG, *St. Louis Med. Rev.*, April, 1910.Abstracted in *THE LARYNGOSCOPE*, p. 660, June, 1910.**1634****The Rapid Diagnosis of Diphtheria by Fixation of the Complement.**WEILLE-HALLE and BLOCK-MICHEL, *Bull. et Mem. de la Soc. hop de Par.*, Bd. 27, p. 707, 1910.

The present knowledge of the occasional unfortunate accidents accredited to anaphylaxis has made the indiscriminate employment of anti-diphtheric serum a dangerous one. A useless injection will develop this hypersensitiveness in a patient and expose him to the possibility of later accidents, as well as diminish the duration of the curative action of later serum therapy. The bacteriological diagnosis which has come to be relied upon necessitates a delay of eighteen hours. With this in mind, the authors have made use of the method of Bordet and Gengou, of fixation of the complement, for a rapid, early, sure diagnosis. As antigen they employed an emulsion in salt solution of the mucus obtained from the tonsils and pharynx on a cotton tampon. Antidiphtheric serum from the Pasteur Institute contained the amboceptor, and fresh rabbit serum the complement. A sheep hemolytic system was employed. Twenty-five cases of diphtheria resulted in fixation; ten cases of non-diphtheritic angina, nine of measles, and three of scarlatina showed hemolysis and were negative.—*Ex.*

1636**Latent Infections of the Diphtheria Bacillus.**P. W. WILLIAMS, *Jour. of Laryngol., Rhinol. and Otol.*, Jan., 1910.

The author defines as latent diphtheria those cases in which the pathological conditions are unaccompanied by obvious illness or by symptoms sufficiently characteristic to be recognizable as those of diphtheria. He divides his cases into three groups and cites examples of each from his practice. The first groups are patients who afford none of the usual clinical indications of diphtheria, are not definitely ill but are simply ailing in association with nasal catarrh, membranous rhinitis, faucial redness or slight subacute tonsillitis, otorrhea, sores etc., which on bacteriological examination proved to be diphtheritic.

The second group are cases with local diphtheria lesion, but presenting no general symptoms of ill-health.

This class comprises cases which are indisputably latent.

The third group comprises persons who present no local lesion and no departure from normal health, but in whom diphtheria organisms have been discovered by culture tests e. g. healthy infected contacts.

For the diagnosis of diphtheria, the author declares we have to depend on bacteriology, and to suggest that the most practical criterion at our disposal which stamps a case as clinically true diphtheria is a virulence test-morphological tests being unreliable. He cites cases which seem to show that non-virulent diphtheria bacilli when transferred from one person to another do not become virulent or give rise to the disease.

WELLS.

1639**Disturbances of the Thyroid Secretion in Northern Mexico.**

WALTER C. ALVAREZ, *Am. Jour. of Med. Sci.*, July, 1910.

In the mountainous state of Sonora, in Mexico, goiter is endemic. A large proportion of the women have enlarged thyroids, and cases of moderate thyroidism are constantly seen. The author reviews at length the various symptoms to which pathological conditions of the thyroid gland may give rise. This article deals particularly with the atypical cases in which symptoms of obscure origin are in reality traceable to thyroid disease. He reports a number of such cases. He thinks many so-called hysterical attacks in women are in reality due to unrecognized thyroid disorder. One of the most confusing features in the study of ductless gland changes, is the intimate relation of all the ductless glands to one another. Hence, one must always keep in mind that the symptoms observed after the extirpation of one of these organs may be due not only to the loss of that organ, but to changes, compensatory or otherwise, in the remaining glands and their internal secretions. The article is a very thoughtful one and should be read at length. PACKARD.

1656**Hemorrhage in Goiters.**

F. BRUENING, *Arch. f. Klin. Chir.*, Vol. 91, No. 3, 1910.

Case of goiter in man which first annoyed him after he fired several shots from a gun. Operation showed the presence of a small hemorrhage in the goiter. Bruening discussing this condition at length and quote six cases in literature. Operative intervention is indicated only in cases of vital necessity.

1657**Lymphocytosis in Exophthalmic Goiter.**

M. BUEHLER, *Muench. Med. Wchnschr.*, May 10, 1910.

From an examination of twenty cases of pronounced exophthalmic goiter and seventy cases with the incomplete form the author concludes that lymphocytosis is always present. The blood-examination may be used as a differentiation test. Though the presence of lymphocytosis is of great diagnostic value, negative findings are not conclusive.

1660**Internal Secretions of the Thyroid.**

A. J. CARLSON and A. WOELFEL, *Am. Jour. of Physiol.*, April, 1910.

The authors give the results of very extensive experiments on the thyroid. They cite evidence to show (1) that the thyroid may assume parathyroid structure and function, and vice versa, and (2) that there is a qualitative and quantitative difference in function between the thyroid and parathyroid under normal conditions. Much is said of the relation of iodine to the function of the gland.

1661

Morphologic Changes in Blood in Simple and Exophthalmic Goiter.

U. CARPI, *Berl. klin. Wchnschr.*, Nov. 7, 1910.

Carpi says: 1. Leucopenia is not a constant symptom in Basedow's disease. 2. Lymphocytosis is one of the more frequent symptoms in Basedow's disease, yet cases are met with in which lymphocytosis is absent and it cannot be said to be a constant condition. 3. A typical lymphocytosis has been observed in myxedema with lymphoid metaplasia of the bone marrow. 4. In simple goiter without thyrotoxic symptoms lymphocytosis has been observed, and it may reach a high point. From these facts it follows that a characteristic and constant condition of the blood of positive diagnostic importance does not exist in Basedow's disease. Lymphocytosis, with or without leucopenia, is to be considered as a general symptom in thyrotoxic diseases.—*Ex.*

1662

Diagnosis and Treatment of Exophthalmic Goiter.

F. CHVOSTEK, *Wr. klin. Wchnschr.*, Feb. 10, 1910.

Chvostek declares that nothing explains so well the Basedow syndrome as the assumption of functional disturbance in the thyroid. He has observed an abortive Basedow syndrome accompanying chlorosis and subsiding with the latter. In other cases tachycardia, tremor, a tendency to sweating and nervous irritability accompanying the chlorosis were probably merely the expression of the effects of the anemia in a neurotic subject. Similar syndromes are observed during the menopause, being the expression of changes in the circulation and nervous system—not true exophthalmic goiter. Cardio-vascular neuroses may also be mistaken for the Basedow syndrome. The difference in the pulse, standing and reclining, is abnormally great; such cases, he says, should not be confounded with true exophthalmic goiter, not even if goiter develops or a tendency to protrusion of the eyeballs is manifest. The anamnesis, the variability of the cardiac phenomena and the irritability of the heart exclude exophthalmic goiter, as also the lack of changes in the heart itself. Lead poisoning may also simulate the Basedow syndrome, and certain cases of cholelithiasis present symptoms on the part of the heart deceptively simulating functional or organic heart disease. He knows of instances in which exophthalmic goiter had been diagnosed under these conditions, but thyroid functioning had nothing to do with them. In a recent case a patient with apparently typical exophthalmic goiter showed no improvement under the usual measures. The discovery of large proportions of fat in the stools and an abnormal appetite suggested some disturbance in the pancreas, and under pancreas organotherapy the entire syndrome rapidly changed for the better, the patients soon regaining full earning capacity. The improvement continued as long as the administration of pancreas extract was continued, but the symptoms returned when it was suspended; they were again banished by resumption of the pancreas extract. It is a question in this case whether the thyroid or the pancreas is primarily

affected. Patience, rest, change of environment and especially a trip to the mountains have proved the main reliance in his experience with treatment of exophthalmic goiter, supplemented by gentle hydrotherapeutic measures. He has never derived any benefit from drugs in exophthalmic goiter; heart tonics generally aggravate the symptoms. Weeks, months or more may be required before satisfactory benefit is realized, but he has always accomplished it in time, and has never had to recommend operative intervention, although he admits that this is justified when internal measures fail or there is compression of the trachea or a long course of treatment is impossible or when the patient demands strumectomy on account of the disfigurement. In the cases in which the Basedow syndrome is only indirectly induced, an operation on the thyroid would do no good. He has never observed better result from Roentgen-ray treatment than have been attained with mere galvanization alone.—*Ex.*

1663

Enlargement of the Thyroid in Rheumatism.

J. R. CLEMENS, *Arch. of Ped.*, Vol. 27, p. 353, 1910.

Clemens states that enlargement of the thyroid may be taken as a sign of rheumatism. The enlargement is apparent before, during or after the course of the disease, and though not great, it gives unnatural fullness to the neck. In children with enlarged thyroids, a careful history should be obtained as to growing-pains, torticollis and recurrent tonsillitis.

1664

Suppurative Thyroiditis During Pertussis.

COLLET, *Lyon Med.*, Oct. 9, 1910.

Case of an 18-months-old infant who developed a streptococcic purulent thyroiditis after a week's attack of whooping cough. A tumefaction appeared on neck which doubled its size in one night. Its skin was red and tender. Almost complete apyrexia. The tumor was cut and drained in the median line. Much pus was found in both lateral pouches on both sides of the trachea. Rapid recovery.

1668

Successful Transplantation of the Para-Thyroid in Case of Thyropriva Tetany.

W. DANIELSON, *Beitr. zur. klin. Chir.*, Jan., 1910.

Report of a case in which a woman of 51 with menacing post-operative tetany after removal of a very large colloid goiter was apparently saved by implantation of two para-thyroids removed from two other patients at the same time during a strumectomy. The glands were transplanted a few moments after their removal, being inserted in a pocket made for them between the fascia and the peritoneum, just above the umbilicus. A few severe convulsions occurred after the transplantation but they rapidly subsided in number and intensity and examination after seven months showed approximately normal conditions. The cir-

cumstances of the case seem to show, Danielson says, that the transplanted glands were mainly responsible for the favorable outcome of the case. The technic for strumectomy to avoid injury of the parathyroids is discussed in detail and the indications for transplantation.—*Ex.*

1669

Syphilis of the Thyroid.

C. F. DAVIS, *Arch. of Internal Medicine*, Jan., 1910.

Davis claims that his is the first case of tertiary syphilis of the thyroid—the diagnosis being confirmed by the anatomic findings—to be reported in American literature; the third reported in the English language, and the eleventh in the entire medical literature.

Twenty cases of gumma of the thyroid have been described. Eight of these were diagnosed only clinically without any definite anatomic proof of their syphilitic origin; 3 cases were diagnosed both clinically and histologically, 8 cases were diagnosed histologically. The remaining case was probably diagnosed clinically—it is specifically stated that histologic examination was not made.

Davis' patient complained of hoarseness, great inspiratory dyspnea and pain on swallowing. The trouble had appeared four months previously, when the patient developed the above symptoms. This condition was constant and was subject to exacerbations at rather frequent intervals, in which the dyspnea was so great that the patient became cyanosed. Hoarseness was marked. There was history of syphilis five years previously; the patient had never suffered from any other serious illness. Examination of the larynx disclosed a paralysis of the adductor muscles. The neck was somewhat tender in the region of the thyroid cartilage; otherwise examination of the neck was negative. Tracheotomy was performed under local anesthesia, and a tube inserted with no relief to the patient; death followed about twelve hours later.—*Ex.*

1671

Thyroid Insufficiency and Adenoid Vegetation.

J. DELACOUR, *Med. moderne*, Oct. 26, 1910.

Though the author admits that adenoids are often due to nutritive disorder yet he feels that the thyroid gland is in part responsible for their existence.

1675

Exophthalmic Goiter Simulating Typhoid Fever.

L. DLUGASCH, *Med. Rec.*, Oct. 29, 1910.

The insidious onset, in Dlugasch's case, with general malaise, headache, nausea, a tongue that looked like typhoid, sordes on tongue, enlarged spleen, suggested typhoid. When first seen the patient had been running a temperature of from 102° to 103.5° F. for about eleven days, but the Widal tests were negative, and on the twelfth day the temperature came down to 98.6° F. In exophthalmic goiter there sometimes is a rise of temperature with enlarged spleen, and it behooves one to make a careful physical examination.—*Ex.*

1677**Injury of Recurrent Nerve During Operation for Goiter.**

F. L. DUMONT, *Deut. Ztschr. f. Chir.*, March, 1910.

In eleven hundred and forty-eight strumectomies, sixteen lesions of the recurrent nerve occurred. In nine cases it was a question of the solution of the continuity, in seven of temporary bruising.

1689**Epidemic of Carcinoma of Thyroid Body in Fishes.**

GAYLORD, *Jour. A. M. A.*, Jan. 15, 1910.

The author cites an epidemic amongst fish, namely the brook trout, salmon and others, in which there were tumors of the jaw, thyroid, gills, with metastases in other portions of the fish. Numbers of the fishes were immune—as the hybrid fish, some Scotch sea trout as well as some brook trout. Cancer in the fish is similar to that in the warm-blooded animal's Epithelioma of the tongue is common in the large fish. The most malignant is the thyroid variety, colloid in type. The author draws the conclusion of the infectivity of cancer through a parasitic origin after citing statistics.

1690**Persistence of Thymus with Exophthalmic Goiter.**

H. GEBELE, *Arch. f. klin. Chir.*, Bd. 93, No. 1, 1910, and *Beitr. z. klin. Chir.*, Bd. 70, No. 1, 1910.

Gebele states that seven died, being nineteen per cent of thirty-six patients with exophthalmic goiter operated on at the Munich surgical clinic. Necropsy was possible in five of the seven fatal cases and a large thymus was found in four out of the five. In six other patients with exophthalmic goiter no operation was attempted. These experiences led to considerable experimental research to determine the influence of removal of the thymus in dogs, implantation of thymus and thyroid tissue, and other experiments on these glands. The conclusions drawn from this research are that the thymus hypertrophies as a natural compensating process to do the work which the diseased thyroid is unable to accomplish; that is, there is a vicarious enlargement of the thymus. The death of persons with exophthalmic goiter and abnormally large thymus has nothing to do with the "persisting" thymus, but must be ascribed to the injury of the heart from the toxic action of the morbid thyroid secretion. He thinks the thymus is probably an epithelial gland rather than a lymphoid organ, and the more pronounced the disease in the thyroid, the larger we may expect to find the thymus. It may be examined by palpation, percussion and radiography, and if it is found enlarged it is wiser to refrain from operating in a case of exophthalmic goiter, he declares, not on account of danger from the thymus, but because its enlargement shows that the thyroid is irreparably damaged, and the Basedow syndrome in such an advanced stage that the chances for operative recovery are practically zero. At the same time, the chief index of the severity of the exophthalmic goiter is the condition of the heart.—Ez.

1693

Eye-Strain a Cause of Exophthalmic Goiter.

G. M. GOULD and A. C. DURAND, *Jour. A. M. A.*, Dec., 17, 1910.

Gould and Durand argue that eye-strain may cause exophthalmic goiter, and report a case which seems to them a proof of this. They say that oculists who are also refractionists have long been curing patients who exhibit the symptoms of exophthalmic goiter. Nothing is more certain than that the eye-strain of ametropia often causes tachycardia or tremor, and frequently both combined. How exophthalmos is produced by eye-strain is not so readily understood and still less the cause of the goiter. The conclusion is suggested that as multitudes of goitrous patients have no tachycardia or exophthalmos, the goiter symptom is somewhat independent or secondary. Probably the tachycardia is the first of the ocular reflexes instituted, followed by the exophthalmos as chiefly a secondary vascular phenomenon. It is not beyond comprehension they say that heightened blood-pressure may induce goiter, although the neurotic origin seems more sensible. In the case reported, the exophthalmos disappeared during mydriasis and returned with its disappearance. With the proper spectacles it gradually and completely disappeared. The authors suggest the use of a cycloplegia test in cases of headache, migraine, neurasthenia, dyspepsia, etc., and ask why it has not been more frequently done, as urged by Dr. Gould.—*Ex.*

1695

The Structure, Distribution and Variation of the Thyroid Gland in Fish.

GUDERNATSCH, *Jour. A. M. A.*, Jan. 15, 1910.

Since the thyroid gland of *Teleostei* is the seat of tumors it seemed of importance to determine its normal features. It is not a compact, uniform organ as in mammals, but is broken up into numerous single follicles which are more or less closely associated. This disintegration and the distribution of the follicles vary not only with the species but also with the individual. The follicles are located around the ventral aorta and its branches to the gills. We usually find them more densely packed in the neighborhood of these vessels, while toward the periphery their arrangement becomes less dense until they finally lie entirely separated. Their distribution extends as far as the other tissues will allow and they creep into any available place. They even invade other tissues, for instance, muscles, as in trout. Laterally the follicles reach out along the gill arteries, and if they find an especially open passage along the vessels they may then invade even the gills. The latter case is found in trout, in which genus the follicles especially show the tendency to break off from a central portion and to spread out toward the periphery. This scattering of the follicles is made possible by the fact that there is no capsule around the thyroid, and since this diffuse arrangement is found in all species examined we must consider it to be the normal condition. The thyroid gland of the *Teleostei* is thus a rather undefined organ in its shape having the tendency to give up its unity and to break up into numerous small parts. This peculiar feature renders it difficult to distinguish between a main body and detached fol-

licles, as we cannot sharply define the main body. The limits between a normal thyroid and a beginning hypertrophy are also rather indistinct, since we do not yet know how extensively the organ may normally develop in the number of its follicles or their wide distribution. This study of the thyroid demonstrates that the follicles may normally be present in regions which might be supposed to contain secondary thyroid tumors, while as a matter of fact such misplaced structures would be a part of the primarily diseased gland.—*Ex.*

1721

Early Diagnosis of Basedow's Disease.

T. KOCHER, *Corresp.-Bl. f. Schweizer Aeuzte*, March 1, 1910, and *Muench. Med. Wchnschr.*, March 20, 1910.

Kocher points out several symptoms which aid in the diagnosis of exophthalmic goiter. He advises operation as the best means of obtaining a complete and rapid recovery.

1737

Case of Fracture of Thyroid Cartilage with Prompt Recovery.

A. C. MATTHEWS, *Jour. A. M. A.*, Sept. 10, 1910.

Fracture of thyroid cartilage in a foreigner. Cured in nine days. Tracheotomy unnecessary. The man remained twenty-four hours without food.

1770

Examination of the Blood in Exophthalmic Goiter.

N. ROTH, *Deut. Med. Wchnschr.*, Feb. 10, 1910.

Roth remarks that the characteristic changes in the blood early in this disease are important for differentiation of the incipient and abortive cases. The proportion of hemoglobin is abnormally low, the number of reds normal or above while the number of whites is below normal. There are also lymphocytosis and mononucleosis.—*Ex.*

1773

Iodoform and Thyroidism.

A. R. SHORT, *Bristol Med. Chir. Jour.*, June, 1910.

The author's conclusions are the following: (1) That iodoform when absorbed by the system, either from a wound or from the bowel, is excreted into the blood by the thyroid gland as iodothyryn, which is the active principle of the colloid of that gland. (2) That an excessive quantity will produce symptoms of acute thyroid intoxication. (3) That in a susceptible person iodoform may precipitate an attack of chronic thyroid intoxication, namely exophthalmic goiter. He has collected about one hundred cases in which iodoform is said to have given rise to a symptom—complex resembling acute thyroidism. He believes that deprivation of iodine is probably the sole cause of parenchymatous goiter. Since, then, iodoform causes thyroidism more readily than iodides, he concludes that iodine should be given in organic combination to cases of parenchymatous goiter.

GUTHRIE.

1779**Note on Aural Manifestation of Myxedema.**

S. MACCUEEN SMITH.

Original contribution to THE LARYNGOSCOPE, p. 545, May, 1910.

1798**Minute Structure of the Thyroid Gland.**

D. C. WATSON, *Lancet*, April 23, 1910.

While investigating the effects of varying diets on the structure of the tissues and organs in rats, Watson found that the histological appearances of the thyroid gland changed greatly. He explains this fact in two ways. Either the appearances represent different stages of activity of the gland comparable to those observed in other secreting glands, these variations being dependent on the stage of secretion, or they represent modifications in the structure and functions of the gland which have been induced by dietetic or other factors in the animal's environment. The former explanation seems not to hold good, since a careful investigation into the nature of the stomach-contents in the different animals, along with a consideration of the microscopical appearances of the thyroid in each case, has yielded evidence against it. The second explanation seems, therefore, to be the more probable, the effects observed indicating that modifications in structure and function of the thyroid gland occur in association with different environmental conditions.—*Ex.*

1811**Anaphylactic Accidents Following the Employment of Antitoxin Serum.**

AUER and LEWIS, *Jour. of Experim. Med.*, March 14, 1910.

From investigations at the Rockefeller institute the authors conclude that death is caused by bronchial spasms in anaphylactic accidents following the use of antitoxin. According to the authors intravenous injection of atropine revives, belladonna and its active principles paralyzes the bronchial muscles and is to be employed only in extremis.

1820**Menstrual Disturbance Following Administration of Diphtheria Antitoxin.**

E. M. COLLIER, *Jour. A. M. A.*, May 7, 1910.

The Doctor reports seven cases of menorrhagia caused by the immunizing doses of anti-toxin given to the nurses at different periods. The serum seems to have had the effect of causing the menses to appear earlier and also increasing the amount of hemorrhage, with a profuse amount of clots.

The Doctor comes to no conclusions and is unable to quote any similar cases in medical literature.

MYERS (GOLDSTEIN).

1828**Medical Treatment of Exophthalmic Goiter.**

S. GILLIES, *Australasian med. Gaz.*, Sept. 20, 1910.

The thyroid gland is an organ whose secretion is of importance. In seven hundred cases myxedema appeared after its removal. Goiter

usually yields to prompt treatment, the factors of which are absolute rest in bed, and regulated diet,—no meat, coffee, tea, alcohol, etc. No case should be operated before being submitted to a medical treatment for a period of three months. If they show no improvement, then operation is indicated. The author also discourses on the various therapeutic methods.

1829

Thyroid Grafting and the Surgical Treatment of Exophthalmic Goiter.

W. H. GROVES and C. JOLL, *Brit. Med. Jour.*, Dec. 24, 1910.

The authors conclude that it is obvious both from a consideration of their case, together with the review of the literature of the subject, that the value of thyroid grafting is by no means settled, but enough has been said to encourage further work in this direction. It seems fairly certain that grafting can be successfully undertaken as far as the immediate vitality of the grafts is concerned. Further, that in recent cases of thyroid inadequacy, a good functional result will accrue from this method. But time only can show what are the permanent results of this method.—*Ex.*

1830

Thymus Gland Treatment of Certain Diseases (Goiter).

F. GWYER, *N. Y. Med. Jour.*, Feb., 1910.

Eighteen cases, comprising goiter, arterio-sclerosis and diabetes, rheumatoid arthritis, haemorrhoids, breast tumor, pulmonary tuberculosis, diseases of the gall-bladder, and cancer, were treated with dried powdered thymus (prepared by the author from fresh glands) in doses varying from thirty to one hundred twenty grains. All showed improvement. In the cases of diabetes no change was effected in the excretion of sugar. All the diseases treated were regarded as the result of imperfect or improper metabolism, the only exception being tuberculosis, the improvement of which is significant, and justifies further trial. As regards cancer, a further and more detailed report is promised.—*Ex.*

1831

Surgical Treatment of Goiter.

W. D. HAINES, *Lancet-Clinic*, March 19, 1910.

Haines, reviewing the literature, embryology, and anatomy of the thyroid gland, presented evidence to show that the syndrome called goiter was due to overactivity of the adrenals induced primarily by an excess of thyreo-globulin in the blood. Discrepancies of opinion in the past were due to a lack of definite knowledge of the actual changes which took place in the gland at the time of observation. Laboratory study had shown a local hyperemia with increase in colloid and diminished staining reaction, but no gross changes in the gland in the first stage. This was followed by hyperplasia, or the second stage. Imperfect alveoli lined with giant cells and great loss in colloid characterized the third stage, while fibrosis, cell atrophy, sclerotic arterial walls, hemorrhage, and cyst formation completed the final steps in the destructive process. Basing treatment upon these findings, he advised diminishing the blood supply by ligating two or more of the thyroid arteries in preference to thy-

roidectomy in the management of cases of hyperthyroidism with a moderately enlarged gland and active symptoms. Ligation was a lighter operation and was not followed by hyperthyroidism. In the operation for the removal of adenoma, or partial thyroidectomy, he kept within the thyroid capsule, thus avoiding injury to the parathyroids and recurrent laryngeals.—*Ex.*

1840

Treatment of Exophthalmic Goiter.

Kocher, *Muench Med. Wchnschr.*, March 29, 1910.

Kocher concludes from the results obtained that the operation on the thyroid gland produces almost without exception an improvement in the disease and if correctly performed may result in a cure. Serious cases which need to be prepared for the operation demand absolute rest and symptomatic treatment of the secondary organic diseases. He finds the use of iodine, thyrodine, the serum, milk and blood of animals from which the thyroid has been removed, antithyrodine, thyroidektin and rodagen to be inconstant and never permanent in their effects. The application of Roentgen and radium rays is not without danger and should not be made by the inexpert. Galvanization and faradization of the thyroid can only be efficient in cases of great vascularization of the gland by contraction of the musculature of the vessels. Hydrotherapeutic applications to the thyroid have the same aim as electricity, but they are less dangerous and often very grateful to the patient. Injections into the gland have been almost abandoned because of serious accidents. Thyrotoxic and cytotoxic serum have frequently proved efficient, but no thorough effect is to be expected on theoretical grounds. More importance may be attained by organ therapy through the more exact knowledge of the chemistry of glands with internal secretion and of the correlations that exist between these glands.—*Ex.*

1857

Surgical Treatment of Exophthalmic Goiter.

C. A. PORTER, *Boston Med. and Surg. Jour.*, Sept. 15, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1065, Nov., 1910.

1864

Surgical Treatment of Diphtheria.

J. W. SHANKLAND, *St. Louis Med. Rev.*, April, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 652, June, 1910.

1869

Untoward Results of Thyroid Medication and How to Forego Them.

H. STERN, *Am. Medicine*, Jan., 1910.

After a long clinical experience S. concludes that thyroid medication is best exhibited when combined with arsenic and some cardiac stimulant. He extolls adonidin a glucoside of adonis vernalis in combination with dimethyl arsenic acid (cacodylic acid). The selected formula is: sodium acodylate 1.200 gr.; adonidin 1.30 gr.; desiccated thyroid gland 1 gr. to each capsule or compressed tablet.

If adonidin cannot be obtained fresh and is prohibitive in price caffeine may be substituted in doses of 1-6 gr.

GOLDSTEIN.

1879**Experiences with the Artificial Tympanic Membrane.**

R. BARANY, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, Nov.-Dec., 1910.

The author claims to have found a method to provoke and suspend at will the effects of an artificial tympanum. By this method can be ascertained which of a series of tones can be better heard with the artificial tympanum.

Important data for the practical comprehension of the phenomena are developed, besides which the experiment is of diagnostic value in determining whether or not any benefit is to be derived from the introduction of an artificial tympanum. For his experiments, the author uses sterile liquid paraffin, which he nevertheless finds of less diagnostic value than the introduction into the ear of a drop of mercury. Method of procedure, physiological proofs and plates further explain the author's theory.

GOLDSTEIN.

1880**Improvement in Hearing by Means of Artificial Drum-Membranes.**

BERND, *Internat. Ztribl. f. Ohrenh.*, Sept., 1910.

The author discusses the various forms of artificial membranes which have from time to time been advocated by such men as Yearsley, Gomperz, Haug, Alexander and others, and concludes that the greatest advance in this somewhat neglected branch of otology has recently been made by Barany whose experiments by means of a drop of mercury in the ear to close off either the round or oval window with a column of air, which the author claims remains between the surface of the mercury and the round or oval window, have produced appreciable improvement in sound-perception.

GOLDSTEIN.

1883**Action of Cerumen on Micro-organisms.**

C. CALDERA, *Arch. ital. di. Otol.*, March, 1910.

We are accustomed to consider the cerumen merely as a protection against infections of the auditory canal and tympanum. This glandular secretion is, however, an eliminated substance which should be removed; for it favors the growth of germs many of which are pathogenic, and thus becomes a permanent source for local infection.

1884**Case of Bilateral Congenital Atresia without Malformation of the Auricle and with Remarkable Good Hearing-Power.**

FEDERSCHMIDT, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61. Heft 2, 1910.

Boy aged 6 years. At 3 years of age, when he began to talk, his parents noticed his deafness. A year before, he had had diphtheria. Family history good. The boy was well-developed but moved about slowly. He spoke plainly, stuttering only occasionally at the beginning of a sentence. Atresia of both canals. C—c³ were heard on both ears; no positive result obtained with the other tones. Bone-conduction not shortened; whisper heard at 4m. The author proposes to operate to open middle ear.

1885**Atresia of the External Auditory Canal.**

E. A. FORSYTH, *Ann. of Otol. Rhinol. and Laryngol.*, June, 1910.

Atresia of the external auditory canal is a rare condition and may be either congenital or acquired. When congenital it is usually associated with malformation of the auricle and middle and internal ear which renders operative interference inadvisable. The patient usually gives a history of suppurative otitis media, which still discharges, or has been followed by deafness. The canal appears as a pale gray or grayish-red glistening cul-de-sac; the further in the atresia extends the shorter the canal appears. By means of a probe the nature of the growth may be determined. The thickness of the atresia may sometimes be determined by the hearing-test; usually absolute deafness in osseous or extensive connective tissue atresia, a considerable hearing distance for speech in membranous atresia, etc. In cases that do not hear even with the aid of a trumpet, operation will aid little. No operation should be undertaken to correct mal-development of the canal unless it be determined that the internal and middle-ear be intact.

The report of a case is appended.

1886**Morphology of the External Auditory Meatus in Mammals.**

L. FREUND, *Passows Beitr.*, Bd. 3, Heft 1 and 2, 1910.

The interesting observations made by F. are recorded minutely in this valuable monograph, the substance of which can be only wholly appreciated by a perusal of the original. The author bases his observations on a large series of experiments carried out on dogs, cats, bovines, pigs, horses, sheep and rats. The determination of the position of the auditory canal in the skull is accomplished by X-ray photographs and the previous filling of these canals with Wood's metal. After hardening the tissues in formalin, the soft parts are dissected away and the relation of bone, cartilage and the moulded parts is determined.

GOLDSTEIN.

1888**Case of Congenital Absence of Both Auricles.**

G. GRADENIGO, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, March-April, 1910.

This is an interesting report of absence of both auricles in an intelligent child of 12 years. The mal-formed auricles existing have the external appearance of exaggerated lobules and contain but remnants of cartilaginous tissue. There is no trace of auditory meatus, cartilaginous or bony auditory canal, conformation of both inferior and superior maxilla is normal. The tympanic cavity lies abnormally deep,—the two larger ossicles are rudimentary, the stapes and vestibular wall, normal. The labyrinth and auditory nerve periphery are normal. G. cites this as an explanation for the independent development of the auditory vesicle involved in the formation of the labyrinth.

All functional hearing tests indicate diminished sound perception dependent upon the conduction apparatus,—the labyrinth and perceptive mechanism are normal.

GOLDSTEIN.

1889**Disturbances of Musical Hearing.**

HAENLEIN, *Passows, Beitr.*, Bd. 4, p. 49, 1910.

H. reports two cases of error in sound-perception. The first case was that of a patient with a healed suppurative otitis media who heard musical chords indistinctly. Even though the hearing capacity was restored to almost normal this error in perception persisted. Patient heard tuning-forks one-fourth or one-half tone higher in the previously affected ear than in the normal ear. This condition persisted for about three months.

In case 2 the hearing-capacity was decreased following intense psychic disturbances. Single tones and chords were erroneously heard. Slight arterial sclerosis; leuetic history. Concerted music was heard by the patient as a confusion of sounds; low tones were heard more distinctly than high tones. Tone-differentiation normal. GOLDSTEIN.

1890**Parasites in the External Meatus.**

J. A. H. HAMMEON, *N. W. Medicine*, Aug., 1910.

Patient complained of pain in the external meatus. No previous history. Examination revealed fresh blood in meatus. This was wiped away, upon which two swiftly crawling bodies—fully developed grubs—were encountered and removed. No pus in meatus membrana tympani inflamed but intact. After eleven days a fly of the blue-bottle type was hatched from one.

1891**Bilateral Idiopathic Perichondritis of the Auricle.**

HUSS, *Passows Beitr.*, Bd. 3, No. 3, 1910.

Case showed no pain, no serous collection, but from the beginning thickening of the cartilage.

1893**Anesthesia of the External Auditory Canal and of the Membrana Tympani with Ethyl Chloride Spray.**

J. C. KOENIG, *N. Y. Med. Jour.*, July 16, 1910.

Abstracted in the March, 1910, issue of THE LARYNGOSCOPE, p. 411.

1897**Voluminous Angioma Pedunculated From the Auricle of the Ear.**

LEVESQUE, *Rev. Hebd. de Laryngol., d'Otol. et de Rhinol.*, Jan. 15, 1910.

Man aged 36 years who had had a tumor in his left auricle since childhood which had gradually increased in size until it was the size of a pigeon's egg. The tumor was mobile and white. Its interior was hard and irregular. It was easily removed, though the hemorrhage was profuse. Cauterization by primary intention. Histological examination showed it to be an angioma in the process of fibroid transformation. No recurrence within six months.

1899**New Operation for Prominent Ears.**

W. H. LUCKETT, *Surg., Gynecol. and Obstetr.*, June, 1910.

Luckett draws attention to the fact that "donkey ears" are anatomically deformed as well as set at an abnormal angle to the cranium. Hence the operations hitherto adopted to rectify the cephalo-auricular angle are not sufficient to restore the normal contour of the ear. A horizontal section through the auricle, just above the level of the auditory meatus, shows that the cartilage of the concha bends outwards at a right angle from the head until it reaches the antihelix, which it forms by being bent backwards upon itself. In prominent ears which are characterized by a bending forwards of the auricle, the antihelix is undeveloped or absent, and the concavity of the concha is continuous with the fossa of the helix. In the other class, which is characterized by a drooping of the upper part of the auricle, the concavity of the concha is continuous with the fossa triangularis and the fossa of the helix, both the ridges of the crura of the antihelix being absent. In less extreme degrees of drooping ears only the upper of these two ridges may be absent.

The antihelix and its crura are produced simply by a folding of the cartilage, and the new operation is for the purpose of reconstructing this fold, at the same time altering the cephalo-auricular angle. On the posterior surface of the auricle a crescentic flap of skin is mapped out by an incision, and removed. A similar segment is removed from the cartilage, and the latter is sutured, as in the Lembert method of suturing intestine, so that the flat surfaces of the cartilages are brought into apposition. The skin edges are then brought together with horse hair. Care must be taken not to button-hole the skin anteriorly, and to avoid septic perichondritis and a haematoma. In cases in which the cartilage is thin and flexible, it may merely be folded and stitched in position.—*Ex.*

1900**Congenital Deafness with Preservation of Static Irritability in Case of Malformation of External and Middle Ear.**

MAUTHNER, *Arch. f. Ohrenh.*, Bd. 83, Hefte 3 and 4, 1910.

The author records an interesting case of one-sided congenital deafness and an intact labyrinth in a 25-year-old adult with congenital deformity of the external and middle-ear. The unusual characteristics found in this case are the evidences of malformation of the first bronchial cleft, associated with a sacculo-cochlear degeneration in congenital deafness, and that the other ear is normal.

GOLDSTEIN.

1902**The Musical External Ear.**

A. O'MALLEY, *Am. Med.*, May, 1910.

There is a peculiar conformation of the external ear in musicians, first observed by J. J. Kinyoun, of Washington, but never reported, which is constant and readily perceptible. The shape of the concha (a shell) is the special phenomenon observable in musicians' ears. In these per

sons the concha is (1) large; (2) deep; (3) rectangular. The lowest border is horizontal, and at right angles with the helix, which makes the outer border of the concha. In singers, even the noted artists, the lowest border of the concha is not seldom out of the horizontal line as this border goes back from the intertragic notch; thus forming a slightly obtuse angle with the antitragus, but this obtuse angle is not found in the instrumentalists. In some singers the lowest border is horizontal, but the antihelix slopes backward slightly.

Ordinarily in musicians the lowest border of the concha is rounded slightly as it joins the antihelix. It is noteworthy also, that the lowest border of the lobule in musicians is commonly almost parallel to the lowest border of the concha, but this formation is not invariable. The only marked exception to this shape of the lobule O'Malley could find is in Joachim's ear. It is a curious coincidence also that musicians almost without exception have large noses.

When, on the contrary, the ear-lines are vertical, and the concha is narrow, with little or no lower border, and the lobule is large and pendant, the person, no matter how intelligent he may be, lacks the musical sense, is tone-deaf. If a child has vertical ear-lines, it is useless to attempt to teach him music. Again, when a person with vertical ear-lines asks a musician to play an instrument the request is merely an act of patient courtesy, and the final applause is willful mendacity or a sign of relief.—*Ex.*

1907

Unusual Sequestrum From Suppurative Otitis Media.

A. H. ANDREWS, *Jour. of Ophthal. and Oto-Laryngol.*, Dec., 1910.

A farmer, 66 years of age, had chronic suppurative otitis media for thirty years, with pain and gradually increasing facial paralysis for the last four months. A radical mastoid operation showed an irregular cavity, the size of a hickory-nut filled with granulations, the bony tegmen was necrosed to the size of a dime, a discharging sinus led into the posterior wall of the auditory canal near the drum and the outer wall of the aqueductus fallopil was eroded and exposed the nerve at the inner wall of the tympanum. Three weeks later, recurrence took place, and a second operation was undertaken two months after the first operation, when a sequestrum was removed comprising the greater part of the petrous portion of the temporal bone. The mass measured one and one-eighth inches long, eleven-sixteenths of an inch wide and seven-sixteenths of an inch thick. Twenty-four days later the patient died of meningitis.

STEIN.

1909

Optic Neuritis and Suppurative Otitis.

J. S. BARR and J. ROWAN, *Brit. Med. Jour.*, March 26, 1910.

The conclusions arrived at by Barr and Rowan are founded on the examination of the eyes and ears of 160 patients. When possible, each individual has been kept under observation until the termination of the ear affection in recovery, either as the result of local treatment or after operation. Barr and Rowan found that apart from optic neuritis,

vascular changes of a lesser degree are frequent (39 times in 160 cases, or about 25 per cent). Cases of purulent middle-ear disease, in which optic neuritis or vascular engorgement of the fundus is present, are much less amenable to local treatment than those in which the fundus is normal. As a general rule, an improvement in the eye condition is accompanied by improvement in the aural condition, while an increase in the intensity of the changes in the fundus or their persistence is associated with less amenability to treatment and greater gravity of the ear condition. The most probable cause of vascular engorgement of the fundus or optic neuritis is serous meningitis (diffuse or localized). Optic neuritis caused in this way is not usually followed by atrophy, and unless there are other symptoms demanding it, opening of the dura mater is unnecessary.

The practical lessons deducible are: (1) a case showing these changes in the fundus should be watched closely, and their existence regarded as an additional reason for the early performance of the radical mastoid operation; (2) if, on the other hand, they show a tendency to clear off, especially with improvement in the ear condition, or if the fundus is normal to begin with and remains so, we may, with more confidence, look for a favorable response to conservative treatment. Barr and Rowan plead for a more systematic general use of the ophthalmoscope in cases of purulent disease of the middle ear, as they are convinced that the trouble involved will be more than repaid by the results, both as regards the progress and prognosis of this disease.—*Ex.*

1910

Elimination of Hexamethylenamin by the Mucous Membrane of the Middle-Ear.

W. M. BARTON, *Jour. A. M. A.*, March 12, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 883, Sept., 1910.

1911

Microscopic Finding in Exudate in Tuberculous Otitis Media.

DE BERARDNIS, *Virchows Arch.*, Aug., 1910.

See abstract No. 1926, p. 523.

1912

Abnormal Dilatation of Jugular Fossa on Floor of Tympanic Cavity with Occlusion of Round Window of Ear.

H. BEYER, *Passows Beitr.*, Bd. 3, Heft 5, 1910.

See abstract No. 2418, p. 567.

1922

Chronic Suppurative Otitis Media with Large Cholesteatoma of Antrum Penetrating into the Middle Cerebral Fossa. Operation. Death from Meningitis.

COMPAIRE, *El Siglo Med.*, Jan. 1, 1910 and *Bol. de Laringol. Otol. y Rinol.*, March-April, 1910.

Man, aged 29 years. When he was 11 years old a play-mate threw into his right ear, some carot beans, which caused him pain and hem-

orrhage. The pains gradually disappeared but left an occasionally dizziness and nausea. Four years ago, Compaird discovered suppuration in right ear and absence of ossicles. The pains became more intense. Antrotomy: Large cholesteatoma extending to the middle cranial fossa; Ten days after the operation cerebro-spinal meningitis developed. Patient succumbed. In this case the meningitis was combined with meningococci and streptococci.

Compaird suggests the possibility of the early pains and nausea being symptoms of a latent meningitis which only required the operative interference to run its full course.

1926

Microscopic Findings in Exudate in Tuberculous Otitis Media.

DE BERARDINIS, *Virchows Arch.*, Aug., 1910.

Cases of simple tuberculous otitis media are rare. The infection is usually a mixed one, which explains the presence of various microbes in the choana-regions. Pure tuberculous forms exist only in cases of rapid development. Staphylococci aureus are generally associated with Koch's bacilli and toward the end dominate and modify to clinical picture.

1927

Teaching the Student the Operation of Paracentesis of the Drum-Head.

H. FRIEDENWALD, *Jour. A. M. A.*, Nov. 5, 1910.

F. describes an appliance used by him in teaching students the operation of paracentesis of the drum-head, an operation which every general practitioner should be able to perform. It consists in doubling the brass plates made to hold the pictures of diseased drum-heads in Bacon's schematic ear model, giving one of the plates a little stem to represent the handle of the hammer. The plates are held together by a screw which allows them to be separated, and a piece of thin paraffin paper is placed between them and screwed tight. This gives a good imitation of the drum-head. The device is inserted in the model and the student, supplied with hand mirror, speculum and paracentesis knife, practices the operation many times. Friedenwald has found it of great assistance to teacher and student.

1930

Cicatrization of Dry Persistent Perforation of Tympanic Membrane.

HECHT, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 9, 1910.

Some authors do not favor the closure of these perforations. Hecht, however, favors closure. To avoid a return of the suppuration, he institutes treatment only two or three months after it has ceased. One can easily convince oneself of the effect which the perforation has on the hearing by temporarily closing it.

1932

Researches on the Bacteriology of Suppurative Otitis Media.

HOUDA, *Passows Beitr.*, Bd. 3, Heft 1 and 2, 1910.

Streptococci are the most frequent bacilli in acute purulent otitis media. In acute otitis the streptococci muccsa has the greatest virulence, leading to complications in three cases. The Fraenkel diplococ-

1934

cus pneumoniae never necessitated operative interference. It is the usual cause of acute otitis media in children, while the streptococcus appears in adults. The bacillus pyocyaneus appeared in six per cent of the cases.

Case of Psychosis as a Complication of Acute Affection of the Middle-Ear.

M. JACOB, *Ann. de Mal. de l'Oreille, du Larynx du Nez et du Pharynx*, March, 1910.

Jacob discusses the etiology and pathology of psychosis as a complication of otitis media. He recommends the lumbar puncture to relieve the cerebral abscess and otogenous meningitis.

1941**Report of a Case of Rupture of Membrana Tympana While Using a Telephone.**

A. F. KOETTER, *Med. Fortnightly*, March 10, 1910.

The author reports a case of rupture of the tympanic membrane, occurring in a stenographer while answering the telephone. Patient felt a popping in left ear, followed by tinnitus, pain and impaired hearing. When seen by author tear in posterior inferior quadrant was diagnosed. Weber to the affected side, Rinne negative, whispered voice four and one-half feet. Perforation allowed to close, catheterization. In six weeks hearing normal, tinnitus disappeared. Author believes the injury can be explained as due to the action of increased air-pressure, the same as that following a blow. Telephone companies should modify instructions, and instruct users of telephone to hold receiver lightly to the ear. Wires should be put under ground. Author agrees with other writers that the use of the telephone does not cause a diminution in the hearing, but advises only persons with normal hearing to enter the telephone service.

A. A.

1945**Acute Purulent Otitis Media and its Treatment.**

E. LAURENT, *Jour. de Med. et de Chir.*, June, 1910.

Abstracted in THE LARYNGOSCOPE, p. 1117, Dec., 1910.

1946**Acute Inflammations of the Middle-Ear and Their Treatment.**

M. D. LEDERMANN, *Med. Rec.*, Sept. 10, 1910.

. Abstracted in THE LARYNGOSCOPE, p. 1103, Dec., 1910.

1947**Acute Otitis Media with Abscess Around the Sinus and Abducent Paralysis.**

LEHMANN, *Deut. Med. Wchnschr.*, July 21, 1910.

Case which presented typical complex of symptoms at first described by Gradenigo, characterized by paralysis of abducens in acute or chronic otitis media. The mastoid and tympanic cavity were filled with granulations, and the bone was diseased upwards to the dura down to the tip, in front to the meatus and backwards quite a distance. In exposing the sinus, which was covered by pulpy granulations, about one and one-half teaspoonfuls of pus oozed. The paralysis of the abducens was

very much improved in the first three days after the operation, so that diplopia occurred only occasionally. The wound healed in four weeks; the paralysis of the abducens had not completely subsided until after ten weeks.

L. ascribes the paralysis of the abducens to the pressure by the abscess and to a circumscribed meningitis at the apex of the pyramid. The rapid improvement within the first few days after the operation is attributed to the relief of pressure. If this, however, had been the only cause, the paresis would not have persisted almost ten weeks. Therefore the slowly recovering paresis must have been due to meningitis at the apex.—*Ex.*

1948

Primary Malignant Tumors of the Middle Ear.

LEVESQUE, *Gaz. Med. de Nantes*, Jan. 29, 1910.

The author considers the pathology of epitheliomata and sarcomata of the middle ear and concludes that only by an histological examination can a diagnosis of neoplasm be made. He believes in immediate and radical operation which relieves if it does not entirely cure the disease.

1951

Acute Otitis Media. Its Causes and Treatment.

R. E. MATHERS, *Maritime Med. News*, Sept., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 104, Feb., 1911.

1963

Etiology, Pathology, Symptoms and Diagnosis of Phlebitis and Thrombosis of the Blood-Vessels when Complicating Purulent Otitis Media.

W. C. PHILLIPS.

Original contribution to *THE LARYNGOSCOPE*, p. 1002, Oct., 1910.

1965

Profuse Bleeding of the Tympanic Cavity in Connection with Acute Otitis Media Consequent to Influenza.

A. REJTO, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 6, 1910.

Case of influenza-otitis in which paracentesis was twice performed because of pain, fever and sensitiveness of mastoid. Four days later, that is three days after the wound had been enlarged, there was profuse hemorrhage from the auditory canal. It was stopped by a tampon, but during the next 13 days every time the tampon was changed it started again.

1967

Artificial Closure of Perforations of Drum Membrane.

E. RICHTER, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Heft 10, 1910.

The author details his method, but rightly remarks that the results cannot be ascertained before one or two years.

1970**Influence of Yielding Cicatrices of the Tympanum Upon Chronic Catarrhal Deafness.**

SCHOENEMANN, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 6, 1910.

The fact that chronic catarrhal middle-ear deafness, contrary to nervous deafness, is dependent on oscillations in the ear, is explained as due to the cicatrices. It was ascertained that chronic middle-ear deafness was present where the cicatrices were yielding, and it is believed that these cicatrices act as pressure-valves and regulate the intra-tympanic air-pressure. It is also conceivable that these thin scabs permit of a gas-exchange between the external ear and tympanum.

1971**Streptococcal Disease of the Middle Ear With Normal Drain and Perfect Hearing.**

S. SCOTT, *Practitioner*, p. 130, 1910.

This rare condition occurred in a child aged 9 years, who for three weeks had complained of slight headache and pain behind the ear, but she had no discharge nor was she in the slightest degree deaf. There was a slight, tender and edematous swelling over the right mastoid. Schwartz's operation was performed, the mastoid was extensively inflamed and pus was present in the posterior cranial fossa. Recovery. A pure growth of streptococcus pyogenes was obtained. There can be little doubt that the latest mastoid infection originated in an infection of the throat, three months previously when the patient was isolated in a fever hospital. The case teaches us that the real importance of admitting the possibility of an otitic origin for an obscure intra-cranial case and this in spite of normal otoscopic appearances and perfect hearing. TILLEY.

1975**Use of Wire Saw in the Radical Operation on the Middle-Ear.**

S. STEIN, *Dan. Klinik*, p. 953, 1910.

See abstract No. 2338, p. 561.

1977**Preliminary Pathological and Clinical Report of a Case of Exfoliation of the Bony Tympanic Wall, Including the Major Portion of the Semi-Circular Canals.**

J. A. STUCKY.

Original contribution to THE LARYNGOSCOPE, p. 1039, Nov., 1910.

1980**Influence of Inflammation of the Middle-Ear on the Olfactory Sensation.**

V. URBANTSCHITSCH, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Vol. 44, p. 258, 1910.

Abstracted in THE LARYNGOSCOPE, p. 445, April, 1910.

1981**Permeability of the Tympanic Membrane to Air.**

V. URBANTSCHITSCH, *Monatschr. f. Ohrenh.*, No. 2, 1910.

According to general opinion absorption of the oxygen of the air in the middle-ear takes place even upon air-tight closure of the tubes, causing a negative air-pressure. Twenty-nine years ago U. indicated the possibility of the permeability of air through the tympanic membrane, and experimentally determined that vaporized sulphur introduced into the ear-drum of a cadaver turned black the filter paper, dipped in a solution of lead and sugar applied to the surface of the tympanic membrane; that upon the introduction of sulphurous vapors into the ear of a living person blackish-gray spots appear on a bougie, which dipped in a lead-sugar solution, is introduced into the tympanum per Eustachian tube, and that the air aspirated from the tympanum and passed over filter paper dipped in lead, turns this paper brown. Since air has a higher specific gravity than vaporized sulphur, the permeability of the tympanic membrane to it is herewith proved. In this way we can explain the fact that the ear-drum may contain air in total closure of the tube (through growths) and in intact membrana tympani. In regard to retraction of the tympanic membrane in such cases, one might say that through the pathological change of the Eustachian tube the tensor tympani may easily be influenced and therewith also the position of the tube.

URBANTSCHITSCH.

1992**Cytology of Chronic Middle-Ear Discharges.**

E. H. WHITE AND O. KLOTZ.

Original contribution to *THE LARYNGOSCOPE*, p. 549, June, 1910.

1992**Note on Eustachian Obstruction.**

W. C. BRAISLIN, *Ann. of Otol., Rhinol. and Laryngol.*, March, 1910.

Study of the presence of tubal symptoms in ear diseases. As symptoms he mentions a snapping sound upon swallowing or blowing the nose, paracusis, pain, itching and tinnitus. Tubal obstruction in chronic middle-ear disease should receive close attention.

1994**Study of Some Casts of Infantile Pharynx with Special Reference to the Eustachian Tube.**

W. C. BRAISLIN, *Ann. of Otol., Rhinol. and Laryngol.*, March, 1910.

The naso-pharynx of infants is low, broad and comparatively long. Its flatness is due to the undeveloped condition of the bones of the skull, the face and especially of the cervical vertebrae, the pterygoid process of the sphenoid, the palate bones, the palate processes of the superior maxillary bones, and the vomer. The inferior development of the nasal cavities may be responsible for a transference of greater relative respiratory importance to the pharyngeal tissues which may account for the relatively greater degree of hypertrophy as compared to the adult.

Because of the differences in the structure of the naso-pharynx in infants adenoid forceps are rarely applicable.

1995**Pure Atrophic Ozena of the Eustachian Tube and Middle-Ear.**

COMPAIRE, *Rev. hebdomadaire de Laryngol., d'Otol. et de Rhinol.*, Oct. 15, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 26, Jan., 1911.

1997**Early Development of the Eustachian Tube and Naso-Pharynx.**

J. E. FRAZER, *Brit. Med. Jour.*, Oct. 15, 1910.

The author regards the Eustachian tube and middle-ear cavity as derived from a recess that is part of the pharyngeal cavity and contains in its walls first, second and probably third arch elements. The nasopharynx is to be looked upon as a secondary enlargement of the primitive pharynx, mainly affecting its roof.—*Ex.*

2000**Meaning and Treatment of Diseases of the Eustachian Tube in Connection with Inflammation of the Middle-Ear.**

UREANTSCHITSCH, *Wochenschr.*, No. 2, 1910.

Salpingitis chronica purulenta is very commonly observed in combination with otitis media purulenta chronica. It can cause an otitis or a tonsillitis. By means of a catheter the author washes out the tube, first with normal salt solution; and then by means of bougies covered with a seventh-tenths solution of nitrate of silver he cauterizes the interior of the tube.—*Ex.*

2001**The Isthmus of the Eustachian Tube. A Contribution to the Pathology and Treatment of Middle-Ear Diseases.**

S. YANKAUER.

Original contribution to *THE LARYNGOSCOPE*, p. 675, July, 1910.

2003**Mnemonic Tables for Normal Labyrinthine Nystagmus.**

J. ADAMS, *Jour. of Laryngol., Rhinol. and Otol.*, Dec., 1910.

The author presents three tables by the aid of which the reactions in the caloric rotation and fistula tests may be easily remembered. He uses a + and — system to designate the different factors.

2004**Contribution to the Histological Technic of the Human Labyrinth.**

G. ALAGNA, *Ztschr. f. Ohrenh. u. f. die Krankh. der Luftw.*, Bd. 61, Heft. 1, 1910.

Rapid method of preparing the most delicate specimens without damaging them.

2005**Chronic Circumscribed Labyrinthine Suppuration.**

G. ALEXANDER, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61, Heft 3, u. 4, 1910.

Interesting report of a case of chronic circumscribed labyrinthitis, investigated clinically and histologically. No sign of inflammation in cochlea. Article is well illustrated.

2006

Functions of Vestibule.

G. ALEXANDER, *Passows Beitr.*, Bd. 3, Heft 6, 1910.

This article, a contribution to the Congress for Experimental Psychology (Innsbruck, April, 1910), presents in terse form the theories of the functions of the labyrinth, of the normal semi-circular canals and of the vestibule. Labyrinth-reflexes and their psycho-physiological effects are also touched upon.

2009

New Methods of Examination, Concerning the Relationship Between the Vestibular Apparatus, the Cerebellum, Cerebrum and the Spinal Cord.

BARANY.

In an excellent article, accompanied by a diagram, Dr. Barany discusses the above subject before the British Medical Association.

He distinguishes between spontaneous disturbance of the equilibrium and that of the disturbance of the equilibrium experimentally produced. He brings out the difference between the direction of falling in a vestibular disturbance and that due to a cerebellar disturbance. He claims that in cerebellar disturbance the patient falls in the direction of the nystagmus which is not influenced by the position of the body, and in a vestibular disturbance he falls in the plane of the nystagmus which is known by the position of the head or trunk. The author explains this phenomena of falling when the head is inclined to the different angles by the innervation of the muscles of the head or trunk by the establishment of a reflex which is controlled by the cells of Dieter's nucleus, with the nerves in the longitudinal bundle in connection with the cells in the cerebellar cortex.

Barany brings out the experiment that after the patient has been turned ten times to the right he points to the right of the examiner's finger in a normal case, but in cerebellar disturbance this spontaneous fault is not obvious if the right side is diseased; he has noticed this condition in healed cases of cerebellar abscess and explains this as due to the innervation of the vermis of the cerebellum.

In another experiment in which the patient has been turned to one side or the other, with his eyes closed and was asked to point to his nose, he had no difficulty in doing this, even though he makes a fault in pointing to the examiner's finger. He explains this as being due to the brachium conjunctivum being intact. He found several cases of hemiathetosis, in which the patient was not able to touch his nose with his finger, but did so with the back of his hand; thus bringing out the fact that the cortex of the cerebellum, with the aid of the brachium conjunctivum so changes the faults that the patient is able to point to his own nose.

MYERS (GOLDSTEIN.)

2010

New Vestibular Symptom in Diseases of the Cerebellum.

BARANY.

Original contribution to THE LARYNGOSCOPE, p. 560, May, 1910.

2011

**Selected Cases of Nystagmus Characterized by Rapid Head-Movements.
Their Diagnostic Value and Theoretic Explanation.**
BARANY.

Original contribution to THE LARYNGOSCOPE, p. 431, April, 1910.

2014

Counter-Audition and After Perception in Labyrinthitis.

J. BARATOUX, *Arch. Inter. de Laryngol. d'Otol. et de Rhinol.*, March-April, 1910, and *Prat. Med.*, No. 4, 1910.

Because of the insufficiency of the Rinne test, Baratoux calls attention to the value of counter-audition and post-perception and the results thus obtained.

Under normal conditions, if we close one ear and apply a tuning-fork to the opposite mastoid, the sound is heard by "counter audition" in the closed ear. But if one closes the other ear the sound disappears for the same reason. When, in diseases of the ear, closure of the meatus of the healthy ear destroys the counter-audition the prognosis is favorable and vice versa. The results are the same if both ears are unequally affected. Such symptoms show diseases of the middle-ear. If the vertex of the tuning-fork be lateralized toward the diseased side and if the tuning-fork placed on the mastoid of the diseased ear be heard better by the other ear we have an incipient labyrinthine affection. If the vertex be lateralized toward the healthy side and if counter-audition be produced on this side the internal ear is diseased. If the sound of the vertex tuning-fork becomes muffled and one closes one of the meati, a post-perception of the sound is produced for a few seconds on this side. A diminution or absence of this post-perception shows an alteration in the transmission-mechanism. In unilateral affection, when the post-perception takes place on the diseased side as soon as one closes the healthy ear, the middle ear is affected. If, however, the post-perception takes place in the healthy closed ear, we are dealing with a disease of the labyrinth.

2016

Diseases of the Internal Ear and Their Relation to the Wassermann Serum Reaction.

BECK, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Heft 1, 1910.

In thirty-four cases of diseases of the internal ear of unknown origin ten reacted positively and definitely to the Wassermann test. The majority of these showed distinct improvement following pilocarpine therapy.

GOLDSTEIN.

2019

The Ear and Multiple Sclerosis.

O. BECK, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Heft 10, 1910.

B. carefully examined a series of cases of multiple sclerosis by detailed hearing tests. In only two cases was there possible evidences of a pathological focus in the region of the auditory nerve and in the cerebellum. He suggests that such examination be made to determine a possible association of the affection of the acoustic nerve in this pathology.

In one of the cases cited there was total deafness and in another a hearing-range of only one-half meter. In both cases, both the cochlear and the vestibular apparatus could be but partially stimulated.

GOLDSTEIN.

2021

Post-Operative Labyrinthitis.

G. BONDY, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 3, 1910.

Man, 28 years old. Two days after radical operation for right chronic otorrhea, all the symptoms of a purulent labyrinthitis manifested themselves. Operation was refused. Two day later a Neumann radical labyrinthine operation was performed, necessitated by meningeal symptoms. The labyrinth was full of pus. Patient died five hours after operation of diffuse purulent meningitis. The author urges the necessity of carefully diagnosing between serous and suppurative labyrinthitis; the latter necessitating immediate operative interference.

2025

Miner's Nystagmus.

T. H. BUTLER, *Brit. Med. Jour.*, March 5, 1910.

Abstracted in THE LARYNGOSCOPE, p. 892, Sept., 1910.

2026

Nystagmography in Man.

BUYS, *Internat. Zntalbl. f. Ohrenh.*, Nov., 1910.

The importance of nystagmus as a labyrinth symptom has advanced so rapidly that some understanding for exact recording of the character of movement, its frequency, its amplitude and all other details by means of various accessory apparatus has become necessary.

The apparatus of Buys consists of a small cylinder which is brought in apposition with the eye-lid and on this cylinder are registered the ocular movements during nystagmus. The apparatus for recording these movements is similar to the cardio-sphygmograph.

Another apparatus as suggested by Wojatschek is mentioned by which linear nystagmus may be recorded.

The disadvantage of both these apparatus is that we are, as yet, unable to record simple rotary nystagmus.

Many valuable observations have been made by means of these recording devices by which definite curves have been found to indicate the several types of nystagmus.

GOLDSTEIN.

2032

Case of Destruction of the Fallopian Canal by Cholesteatoma with Preservation of the Facial Nerve.

B. CHONOSHTITZKY, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 9, 1910.

Almost the whole Fallopian canal was destroyed and the facial nerve exposed during the greater part of its course. Only at both bends of the nerve is the canal preserved, and here too the facial nerve adheres closely to the bone. The nerve is in good shape though the surrounding bone is destroyed.

2033**Nystagmography.**

H. COPPEZ, *Presse Med. Belge.*, Jan. 16, 1910.

The author publishes the first series of nystagmograms taken from patients with eye diseases. For comparison he uses a case of miner's nystagmus of undoubted vestibular origin and finds that the first type is associated with movements of irregular rapidity, and the second of the pendular or regular type.

These findings are contrary to those of Bielchowsky who claims that in nystagmus of vestibular origin, the movements are irregular; when of ocular origin, they are pendular or regular; when of nervous, central origin, movements may be of either type, depending upon the affection.

GOLDSTEIN.

2034**Etiology of Oto-sclerosis.**

P. CORNET, *Arch Internat. de Laryngol., d'Otol. et de Rhinol.*, Sept-Oct., 1910.

In seventeen patients in whom a diagnosis of otosclerosis was made, Cornet found well-defined constitutional conditions as follows: Arterio-sclerosis, in eight; gastro-intestinal intoxication in four; atonic dyspepsia in one; hepatic congestion in one; renal insufficiency in two; and debility from frequent pregnancies in one.

It is his opinion that decided nutritive changes may be found whenever this aural condition exists: A diminution in the excretion of sodium chloride is the most frequently constant of these. GOLDSTEIN.

2035**Third Contribution to the Study of the Etiology of Otosclerosis.**

D. CORNET, *Rev. hebdomadaire de Laryngol., d'Otol. et de Rhinol.*, Feb. 12, 1910.

This article is a continuation of the author's valuable research work in this field. In this paper he discourses on the gastro-intestinal complication of this disease.

2037**Present Status of Vertigo Considered from a Diagnostic Standpoint.**

G. E. DAVIS, *Jour. A. M. A.*, Oct. 8, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1041, Nov., 1910.

2039**Labyrinthine Nystagmus.**

J. S. DE MUTH, *Jour. of Ophthal. and Oto-Laryngol.*, May, 1910.

Each canal produces a nystagmus in its own plane and to its own side. As there are three canals, there are three kinds of nystagmus, or nystagmus in three different planes, horizontal, superior and posterior.—*Et.*

2045**Physiologic Vestibular Nystagmus.**

J. P. FLETCHER, *Trans. Chicago L. and O. Soc.*, Feb. 15, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 923, Sept., 1910.

2047**Conceptual Factors in Vertigo and Nystagmus.**

P. FRIEDENBERG, *Med. Record*, April 23, 1910.

The various forms of vertigo, visual, rotational, and mixed, are analyzed from a psychological basis and the ocular reaction reduced to its simplest terms. The idea that nystagmus is a cause of dizziness is rather widespread, but there is no evidence in its favor and this view is devoid of any teleological or rational probability. Nystagmus becomes intelligible and can be studied only as a definite reaction to regain balance by means of ocular fixation effort. This basic principle facilitates the study of labyrinthine vertigo by supplying a definite scheme or norm in the physiological fixation modes used in fixing objects in regular rotation in the visual field. Vertigo depends greatly on emotional and intellectual data and may be considered as a confusion of judgment as to subjective motion; or as to the relation of the individual to motion in external or ideal space.—*Ex.*

2048**Surgical Significance of Nystagmus and Vertigo.**

P. FRIEDENBERG, *Am. Jour. of Surg.*, June, 1910.

Friedenberg says that in labyrinthine nystagmus the following phenomena are characteristic: 1 The affected side is the weaker. In standing or sitting the body inclines or falls to the diseased side. In walking or hopping there is a deviation to the diseased side, the patient does not stand securely on the leg of that side, and the body can be more easily pushed to that side. The body muscles tire rapidly, so that in hopping, the jumps not only deviate from a straight line, but the distance between them becomes smaller and smaller, until finally they "mark time," and are made on one spot. Falling can be prevented by merely giving the patient a finger, as the slightest tactile sensations will compensate for the labyrinthine defect. Falling is sudden, unexpected, and complete. The patient collapses without regard for possible injury and without power of preventing or compensating the loss of balance, so that the necessary precautions to guard against injury to the patient should always be taken by those who institute these tests.—*Ex.*

2049**The Vestibular Nerve in Relation to Equilibrium and its Disturbances.**

P. FRIEDENBERG, *N. Y. State Jour. of Med.*, 1910.

A classical monograph of the phenomena of balance and the significance of their reactions in disease.

The author describes the anatomical and physiological associations of this intricate subject, and how appreciation and judgment of motion and position is acquired and formed under, and largely guided by visual impressions, and by impressions of eye-position, and motion in fix-

ation, whether actual and present, sub-consciously remembered, or even only intended.

To fully appreciate this interesting paper it must be followed verbatim and the reviewer earnestly recommends its perusal to those working in this special field.

LEDERMAN.

2050

Element of Vibration in Otoscleroses.

E. FROESCHEL, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, July, 1910.

The author proves, by means of a specially constructed instrument, that in otosclerosis, even in the deeper portions of the auditory canal, the sensibility is lessened.

O. BECK.

2051

New Symptom in Otosclerosis.

E. FROESCHEL, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Heft 1, 1910.

In cases of chronic sup. otitis media, otosclerosis and many cases of suspected otosclerosis, F. found an absence of the sensation of tickling in the ear.

GOLDSTEIN.

2055

Graphic Registration of Vestibular Nystagmus.

G. GRADENIGO, *Arch. ital. di Otol. Rinol. e Laringol.*, March, 1910.

After relating Buys' experiments on this question, Gradenigo describes an apparatus invented by him to register rotary nystagmus. It is analogous to that of Buys but has this advantage that it is fixed to a specially devised revolving chair and begins the registration during the turning. The author merely touches on post-nystagmus.

2057

Clinical Significance of the Derivations of Hiatus Semilunaris.

L. GRUENWALD, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, Heft 2, 1910.

Gruening points out the interesting connection between the anterior ethmoid cells and the frontal sinus, and the orifice of the maxillary sinus. These diseases may simulate those of the maxillary sinus or maintain an inflammatory condition in it. In pus-retention and cyst-formation of these sinuses eruptions occur in the vicinity of the lacrimal bone which have apparently a direct connection with the maxillary sinus. The proximity of the derivations to the nasal hiatus explains the teratological changes in the maxillary sinus and the region between eye and nose.

2061

Traumatic Lesions of the Internal Ear. Clinical and Medico-Legal Study.

E. HALPHEN, *These de Paris*, 1910, and *Gaz. Med. de Nantes*, Sept. 3, 1910.

Among other things the author draws this conclusion that a diagnosis of labyrinthine deafness of traumatic origin cannot be made from otosclerotic deafness of the labyrinth. Traumatic deafness due to labyrinthine lesion is serious, definite and incurable. Vertigo-symptoms quickly disappear.

2063**The So-Called Wanner Symptom.**

J. HEGETSCHWEILER, *Ztschr. f. Ohrenh. u. f. Krank. der Luftw.*, Bd. 60, p. 257, 1910.

The author found in a patient with cranial trauma, the Wanner-symptom—shortening for bone-conduction in otherwise normal hearing.

2064**Sclerotic Deafness and Re-education of Hearing Through Vocal Phonetic Method of Zund-Burguet.**

J. HELSMOORTEL, *Bull. Acad. roy. de Med. de Belgique*, Feb., 1910.
See abstract No. 2709, p. 595.

2066**Pneumatic Aspiration and Compression in the Researches of Vestibular Reactions.**

C. HENNEBERT, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, March-April, 1910.

The fistula-symptom does not only appear in cases of labyrinthine fistula; it is also present in cases of labyrinthitis due to hereditary or acquired syphilis.

In cases of fistula, compression always gives more intense re-action than rarefaction. In hereditary or acquired syphilitic labyrinthitis, the movement of the eyes is always in a horizontal plane, and the amplitude is proportional to the intensity of the stimulus. During compression the eyes are directed toward the "diseased" ear, during rarefaction from it.

2072**The Recognition and Measurement of Low Degrees of Nystagmus.**

E. JACKSON, *Ophthalm. Rev.*, Jan., 1910.

The method of observing nystagmus here described consists in noting the character of the movements executed by definite structures in the ocular fundus as seen in the erect ophthalmoscopic image. With drawing the observer's eye until the optic disc appears to occupy the whole of the pupil one observes the apparent extent of the movements, whether a given vessel appears to pass entirely across the width of the pupil with each excursion of the eyeball, or only one-half or one-fourth of that distance. From this, by brief calculations or from the tables given, the real extent of lateral or vertical movement is to be deduced. Perhaps it is not necessary that all cases of nystagmus shall have the extent of movement exactly measured. Yet this can properly be required for cases reported to take their place in the literature of the subject; and it will be found very satisfactory, in attempting to judge by the extent of the movements, as to the progress of any case under treatment.—Ex.

2073**Clinical Diagnosis of Oto-Sclerosis.**

H. KALENDA, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 60, p. 229, 1910.

Report of case in which the right ear showed functional disturbance in sound perception, while in the left ear the labyrinth seemed to be affected. The author attempts to illustrate that in oto-sclerosis labyrinthine symptoms are not always of a secondary nature, but that a type exists in which disturbances first occur in the inner and then in the middle ear.

2074**Investigation of the Function of the Static Labyrinth in Deaf-Mutes.**

S. KARO, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61, Heft 3-4, 1910.

The author draws the following conclusions from an examination of seventy-five deaf-mutes: The chief cause for the deafness was some form of cerebral disease though scarlet fever and measles were potent factors. There was an excess of male deaf-mutes as compared to female. Myopia was a frequent complication. Pathological changes in the drum membrane were of more frequent occurrence in acquired deafness. Twenty per cent of those examined showed spontaneous nystagmus. The various nystagmus tests were negative in almost all the cases of total bilateral deafness; the test by means of the turning chair gave a more distinct result than any other. The galvanic test agreed almost always with that of caloric nystagmus with cold water; with warm the reaction was uncertain. In cases of acquired deafness the disturbances in the static labyrinth were greater than in those of congenital deafness, but the disturbances themselves were not as pronounced as those in the acoustic labyrinth. The goniometer test is of great aid in a diagnosis of labyrinth affection.

2079**The Ductus Sacculo Cochlearis in Higher Mammals and in Man.**

A. KRAUT, *Ztschr. f. Ohrenh. u. Krankh. der Luftw.*, Bd. 60, p. 61, 1910.

Kraut found in his experiments on mammals and the human that in the new-born only the ductus sacculo cochlearis has an open lumen, later it becomes obliterated. This was true in all cases except in that of pigs, where the condition in the adult is similar to that in the new-born.

These researches prove that the cochlear is differentiated as a separate organ of hearing, from the rest of the labyrinth through the obliteration of the ductus reuniens, due apparently to more advanced development.

2084**Rinne Negative in Unilateral Labyrinthine Deafness.**

LERMOYER and HAUTANT, *Ann. de Mal. de l'Oreille du Larynx du Nez et du Pharynx*, Jan., 1910.

The author attempts to prove that where total unilateral labyrinthine deafness is claimed but no false Rinne negative is found, the deafness is always feigned.

2085**Value of Vestibular Nystagmus As An Indirect Proof of Cochlear Function in Legal Medicine.**

LERMOYEZ and A. HAUTANT, *Ann. de Mal. de l'Oreille, du Larynx, du Nez et du Pharynx*, April, 1910.

Neither the condition of the cochlear nor the state of the posterior labyrinth (vestibularis) permit of drawing a reliable conclusion as to the rest of the labyrinth. Vertigo may be present in an objectively intact vestibule just as we find annoying noises in a healthy ear. Barany's symptom of the caloric reaction is one of the most valuable discoveries in legal medicine, but it must not be substituted for an examination of the cochlear, in proof of which the author cites two instances.

2091**Case of Chronic Circumscribed Pilo-Labyrinthitis.**

F. MALTESE, *Arch. ital. di Otol. Rinol. e Laringol.*, June, 1910.

M. speaks of a clinical case and asserts that a form of chronic pilolabyrinthitis exists, limited to the external semi-circular canal. It is secondary to chronic otitis media and especially to cholesteatoma. This affection may remain circumscribed or extend to the other canals and to the meninges.

LASAGNA.

2096**Symptoms of Internal Ear Suppuration with Report and Presentation of Two Cases; Operation; Recovery.**

J. MCCOY.

Original contribution to *THE LARYNGOSCOPE*, p. 104, Feb., 1910.

2097**Cadaveric Changes in Inner Ear.**

F. NAGER and U. YOSKII, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 60, p. 93, 1910.

For this experimental study, the authors noted the changes in decapitated guinea pigs compared to those in animals fixated by an injected narcosis. They detail their discoveries.

2098**Clinical Study of Infectious Diseases of the Labyrinth.**

H. NEUMAN.

Original contributions to *THE LARYNGOSCOPE*, p. 1027, Nov., 1910.

2103**Two Cases of Labyrinthine Disease Following Chronic Suppuration (Cholesteatoma).**

N. H. PIERCE.

Original contribution to *THE LARYNGOSCOPE*, p. 992, Oct., 1910.

2109**Tuning-Fork a¹ and Labyrinthitis.**

SCHEIBE, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 5, 1910.

Scheibe's case verifies Bezold's theory that absolute deafness and labyrinthine suppuration are present if in the course of a suppurative otitis media a¹ cannot be heard, and vice versa.

2114**On the Functional Examination of the Labyrinth.**

L. SEWELL, *Med. Chron.*, March, 1910.

This paper contains a short account of the rotation, caloric and fistula tests together with the recognized explanation of the nystagmus in each case.

GUTHRIE.

2118**Answers to Boesch's Article on the Aqueduct of the Vestibule as a Route for Infection.**

F. SIEBENMANN, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 60, p. 243, 1910.

The author calls attention to the various criticisms of Boesch's work; that of Wagener, etc.

2124**Head-Nystagmus.**

E. URBANTSCHITSCH, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, Jan.-Feb., 1910, and *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Heft 1, 1910.

2128**On Adaptation in Nystagmus.**

L. WEEKERS, *Ann. de la Soc. Med.-Chir. de Liege*, Vol. 49, 1910.

Failure of adaptation to variations in light is a symptom of the more severe cases of nystagmus. When a miner, suffering from this disorder, descends into a coal pit, he is unable for the first few minutes to see anything but the lights carried by his fellows, and not till after some minutes can he see his way about. Similarly, on returning to daylight, he is dazzled for a time, and needs support in order to prevent himself from falling. The more severe the case, the longer is the time taken by the patient to adapt himself to a change of light. The author has studied this symptom by means of an instrument, the "adaptometer" of Nagel, which registers the minimum light perceived by the subject under examination. If the results are expressed in the form of a curve, the normal person shows no adaptation for the first ten minutes. The curve then steadily rises for the next forty or fifty minutes, after which it remains stationary. Miners who do not suffer from nystagmus show an adaptation often above the normal, and the same may be true of those whose nystagmus is not sufficiently severe to give rise to subjective symptoms. But in the more serious cases, either the curve is normal in shape, but shows a retardation in the rise, or, in addition to delay, there is a failure to reach the normal height. The defect in the

curve according to the author's observations is a measure rather of the patient's consciousness of his disorder than of the actual range of the ocular movements.—*Ex.*

2134

The Value of the Wassermann Reaction in Otolology.

L. ARZT, *Arch. f. Ohrenh.*, Vol. 81, p. 180, 1910.

Among forty-two cases of chronic ear disease, both suppurative and non-suppurative (exclusive of otosclerosis) and ten cases of acute otitis, the author found a number of positive reactions. In some of these cases the positive reaction gave the first indication of the exact nature of the disease, while in one case, which had been regarded as specific, a negative reaction aided in establishing a correct diagnosis.

Of twenty-one cases of otosclerosis not one showed any sign of positive reaction. As both hereditary syphilis and the acquired form which has not been treated antispecifically may be expected to yield the highest percentage of positive reactions the entire absence of such reactions in these cases is regarded as sufficient to exclude lues from any participation in the etiology of this disease.

YANKAUER.

2137

Cartilage Conduction in Tuning-Fork Tests.

BARANY, *Rev. mens. des. Mal. de l'Oreille*, Heft 1, 1910.

Barany explains certain findings in his tuning-fork tests by the following theory: Tone-waves are, for the greater part, conducted from the cartilage to the air and into the middle-ear by air-conduction.

2138

New Method of Tuning-Fork Tests and Their Practical Significance.

R. BARANY.

Original contribution to THE LARYNGOSCOPE, p. 97, Feb., 1910.

2139

Adoption of an International Tuning-Fork in Acoumetry.

J. BARATOUX, *Prat. Med.*, No. 5, 1910, and *Arch. Inter. de Laryngol. d'Otol. et de Rhinol.*, July-Aug., 1910.

The author comments favorably on the adoption of a uniform formula but shows that certain discrepancies will arise unless a uniform tuning-fork series be adopted.

2141

On the Use of the Wassermann Reaction in Otiatics.

K. BECK, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 60, p. 217, 1910.

In an examination of one hundred deaf-mutes with the Wassermann reaction, three positive reactions were obtained. In all of these cases the family history was negative. Hereditary lues is not a negligible factor in the diagnosis of lues as the etiological cause of deafness although until now little attention has been given to this cause.

2144**Spontaneous Hemorrhage from the Ear.**

BISTRIZ RAYA, *Inaug. Dissert.*, Zurich, 1910.

Author discourses on the various form of acute external otitic hemorrhage—traumatic, vicarious, etc. Twenty-eight cases are given in which the causes were colds, especially grip. The characteristic symptoms are blood-blisters or diffuse hemorrhages and ecchymoses in the external meatus or on the drum membrane. Tinnitus, temporarily impaired hearing, pains in head and dizziness are also usually concomitant. Therapy consists in incising the existing blood-blisters.

2145**The Social Hygienic and Economic Aspect of the Ear.**

C. J. BLAKE.

Original contribution to THE LARYNGOSCOPE, p. 15, Jan., 1910.

2146**Remarks on the Uniform Method of Recording Functional Tests.**

E. BLOCK, *Arch. f. Ohrenh.*, Bd. 82, Heft 1-2, 1910.

Article is a criticism of the proposed adaptation of a uniform formula for functional tests.

2155**Latest Advances in the Study of Tinnitus Aurium.**

D. B. DELAVAN, *Ann. of Otol. Rhinol. and Laryngol.*, March, 1910.

Delavan gives a resume of the discussion of this subject at the Laryngological Congress at Belfast, June 27, 1909.

2159**New Rational Objective Measurement of the Intensity of Sound and Capacity of Hearing.**

M. T. EDELMANN, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61, Heft 3-4, 1910.

The author discusses (1) the choice of a rational unit of tone-intensity. For the tone unit "1" he selects the tone volume as produced by the pressure of a 1/10 mm. column of water in a siren; a new arrangement of clamps on tuning-forks, a change in the distance between the lines and an elastic handle and a re-standardization of forks dependent on such tone unit.

GOLDSTEIN.

2161**Auditory Curves. Their Symptomotological Value in Topographic Diagnosis of Otopathies.**

E. ESCAT, *Ann. des Mal. de l'Oreille du Larynx du Nez et du Pharynx*, June, 1910.

E. advocates as a method of recording functional hearing tests an auditory chart containing a parabola of five fixed points: (1) The low tone limit as determined by the low turning-forks of Edelmann and Gradenigo; (2) Audition of low tones 64 to 128 v. d.; (3) Medium and range from 435 to 512 v. d.; (4) High tone capacity of tuning-forks from

2048 to 2072 v. d.; (5) Extreme upper tone limit as measured by Galton whistles, Koenig cylinders and Schuetze monochord. Hypoacusis is classified according to these charts in one of three types and by carefully tracing the curves on such hearing charts, the character of auditory affection may be seen at a glance.

GOLDSTEIN.

2163

Auricular and Peri-Auricular Dermoids, Fistulae and Tumors of Congenital Origin.

J. H. EVANS, *Brit. Jour. of Children's Dis.*, Nov., 1910.

After a concise description of the development of the external ear, the occurrence of accessory auricles, fistulae of the external ear and cysts and tumors around the ear—classified as auricular and pre-auricular, and peri-auricular, supra-auricular and post-auricular—are discussed, and the author expresses the opinion that the rarer tumors known as congenital cholesteatomata arise in connection with the development of the otic vesicle.—*Ex.*

2166

Recommendation by Otologists of Electric Hearing Devices with Demonstration of New Apparatus.

S. FLATAU, *Passows Beitr.*, Bd. 3, No. 6, 1910.

The author recommends the new devices—five types—brought forth by the Berlin Private Telephone Company, because of their freedom from accessory noises, and their trueness and clearness of sound.

2169

Sero-Diagnosis of Syphilis in Its Relation to Diseases of the Ear.

E. P. FOWLER, *Ann. of Otol. Rhinol. and Laryngol.*, June, 1910.

The author arrives at the following conclusions: Syphilis is more frequently associated with diseases of the ear than clinical observations would suggest. The reason for its non-recognition has been the lack of a reliable test for its detection, its denial by the patient or parents, and the failure on the part of the surgeon to look for the disease. In Noguchi's modification of the Wasserman reaction we possess a simple, inexpensive and valuable test for active syphilis. In children suffering from ear disease, females are congenitally syphilitic twice as often as males. In adults the greater proportion having the disease is in the male sex. The proportion of positive reactions in adults and children is about equal. In children with ear disease the great majority of positive syphilitic reactions occur in cases suffering from suppurative diseases of the middle-ear and its surrounding bony cavities. In adults the greater number of positive reactions occur in cases of nerve-deafness and chronic catarrhal otitis media. The presence of hypertrophied tonsils and adenoids seems to bear no relationship to the complement fixation reaction.

Marked benefit to the auditory apparatus and to the general health regularly follows antisyphilitic treatment in cases giving a positive syphilitic reaction. Approximately twelve per cent of all diseases of the middle or internal ear give strongly positive reactions to the comple-

ment fixation test. Syphilitic affections of the internal ear would appear, as a rule, to be late manifestations of the disease. A chart of the results obtained with Noguchi's modification of the Wassermann in diseases of the ear is appended.

2172

Relation of Skin-Sensibility and Sense of Vibration and a Method of Examining the Sense of Vibration in the Ear.

E. FROESCHEL, *Med. Klinik*, Sept. 4, 1910.

Interesting report of experiments performed on a large number of patients suffering from ear diseases, especially otosclerosis and deaf-mutism.

2173

Hearing Tests in School Children.

G. GELLE and C. HENNEBERT, *Arch. internat. de Laryngol. d'Otol. et de Rhinol.*, Nov-Dec., 1910.

After an exhaustive discussion of this subject in its details, the authors formulate the following conclusions:—

In consequence of the unsuspected large amount of partial, total or insidious deafness, the acuity of all school children should be systematically measured.

This approximate measurement should be made of each child for the whispered and the ordinary spoken word, the other children writing a dictation upon the blackboard with their backs to the speaker. These tests, preferably made by a specialist, may be directed and carried out by a trained assistant not necessarily a physician. The results should be tabulated and all parents of children affected with any form of deafness should be notified upon printed forms with the advice to consult a physician.

Examinations should be repeated annually, if possible, every six months. Those slightly affected should be seated near the teacher but all who are unable to hear the whispered word at two meters will not profit from their attendance in the ordinary school-room. These should have individual instruction or special instruction for deaf-mutes.

The average scholar should be considered too. His sound perception should not be over-taxed by too large school rooms. A room of from eight to nine meters square seems most advantageous for the voice of the teacher and for the ear of the pupil.

GOLDSTEIN.

2174

Indications for Egypt in Certain Oto-Laryngological Diseases.

R. GOLDMANN, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Heft 2, 1910.

The author mentions the prophylactic as well as the therapeutic value of the climate of Egypt in acute and chronic diseases of the ear, nose and throat.

2175

Acoumetry with the Tuning-fork Held at a Distance.

G. GRADENIGO, *Arch. ital. di Otol. Rinol. e Laringol.*, July, 1910.

This article is but a preliminary report of investigation made in conjunction with Stephani. If the tuning-fork be held at a distance of from

one to two meters from the ear, the mixing of the vibration in the ambient air eliminates certain errors, such as those of the position of the arms of the fork, their inclination, etc. On the other hand there is greater danger of interference with the sound-conduction, and it is on the elimination of this factor that the author is working.

2177

Clinical Study of Tumors of the Acoustic Nerve.

C. GRADIN, *These de Paris*, 1910.

The author discusses methods of procedure for tumor of the acoustic nerve, but prefers the operative, especially at the early stage of the growth.

2179

Experimental Injury of the Ear of Birds Through Sound.

K. GRUENBERG, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 62, Heft 1, 1910.

For his experiments G. uses pigeons, holding a sounding Galton whistle of sustained tone to the auditory meatus, subjecting the birds to the same experiment daily for from one to two weeks, then decapitating them.

Histologically he found in a number of such birds a considerable degeneration in the ductus cochlearis and most pronounced in that part of the papilla acoustica next to the membrana basilaris.

While no definite conclusions have been drawn concerning the relations of these experiments to the Helmholtz theory, G. observes that if these changes are actually produced by sound penetration, they will depend on the area involved, the position within the ductus cochlearis and its relation directly to the papilla acoustica.

GOLDSTEIN.

2180

Pediatrics and Otiatics.

E. GRUENING.

Original contribution to *THE LARYNGOSCOPE*, p. 801, Aug., 1910.

2181

Congenital Tumors and Deformities in Ear and Nose.

L. GRUENWALD, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 66, p. 270, 1910.

G. reports a case of dermoid of the middle-ear cavity and its significance in relation to cholesteatoma. He emphasizes the fact that definitely recognized congenital neoplasms are of importance in the explanation of pathogenesis of cholesteatoma and of epidermal neoplasms.

GOLDSTEIN.

2188

Comparison Between the Galton Whistle and the Schulz Monochord in Determining the Upper Hearing Range.

HELMHOLTZ, *Inaug-Dissert.*, Berlin, 1910.

The monochord has this advantage over the Galton whistle that it gives constant clear high tones. It has, however, these disadvantages: In its present form it is unhandy, and the tones in the upper range are

faint. On the other hand by means of the monochord the upper tone-range may also be determined for bone-conduction.

2189

Tumors of the Acoustic.

F. HENSCHEN, *Hygieia*, p. 30, 1910.

H. has collected the published cases from 1819 up to date, altogether one hundred and thirty-nine, with nine of his own.

The acoustic tumor has its origin at the bottom of the internal auditory canal, growing from here into the cranial cavity. It appears as a tumor in the angle between the pons and cerebellum. It is fibroid in formation and benign in character.

KIAER.

2191

Some Tuning-Fork Tests with a Special Auscultation Tube.

L. M. HUBBY, *Ann. of Otol., Rhinol. and Laryngol.*, Sept., 1910.

Hubby reports on Barany's new method of making tests, by placing one end of an auscultation tube in the examiner's ear, and the other in the patient's while applying a tuning-fork to the patient's mastoid auricle or to the auscultation tube with varying degrees of pressure. The intensity and duration of the notes as heard by patient and examiner are compared. The advantages of this method are reviewed.

2195

Etiology of Othematoma.

K. KIRCHNER, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 9, 1910.

The first case was one of a railroad employee who often had to crawl under locomotives, during which his right ear would be forcibly pushed against the iron. This caused a typical othematoma. In the second case the growth was caused by friction following the freezing of the ear, and in the third—that of a cabinet-maker—by the frequent grazing of boards against his ear. All cases were cured without operation by the use of iodide of potassium salve.

2196

Reaction of Sound Stimulus on Animals Without Hearing Apparatus.

O. KOERNER, *Zntrbl. f. Physiol.*, Bd. 23, No. 17, 1910.

The author records his experiments on a thread-like worm, *tubifex rivulorum*, found in very large numbers in the mud of slowly flowing streams. The animal lives with its head in the mud. It has no auditory vesicle. Reactions were obtained.

2199

Traumatic Hysteria of the Ear.

O. KUTVIRT, *Leharske Rozhledy*, No. 1, 1910.

The author emphasizes the importance of a differential diagnosis between traumatic hysteria and neurosis. It is easy to diagnose hysteria of the ear when it is concomitant with other hysteria-symptoms, but when the affection is limited to the ear, as it sometimes

though not frequently is, the case is more difficult. Kutvirt points out certain differentiating symptoms. He feels that surgical interference should be indicated only in exceptional cases and as a last resort.

2200

Subjective and Objective Sense of Sound Perception.

D. B. KYLE.

Original contribution to THE LARYNGOSCOPE, p. 57, Jan., 1910.

2203

The Otitis of Ozena.

LANNOIS and JACOD, *Ann. des Mal. de l'Oreille, du Larynx, du Nez et du Pharynx*, Oct., 1910.

Attention is directed to the frequencies of middle-ear disease as a complication, or sequence, of atrophic rhinitis and to the similarity of the evidences of the affection in the cases of suppurative middle-ear disease. With reference to the frequency of the aural sequence authorities differ, more recent observers contributing the larger percentages—Michel in 1876, Loewenberg in 1885, and Jurasz in 1891, reporting but few cases; the latter writer finding but twelve cases of aural complication in one hundred and seventy cases of ozena. Zaufall, on the other hand, estimates the aural sequence of atrophic rhinitis at eighty per cent, and Morf at forty-seven and five-tenths per cent, including aural lesions of various forms. The investigations of the authors substantiate the estimates of Morf, and they have moreover determined a delimitable form of suppurative middle-ear affection occurring during the course of the atrophic rhinitis as a subacute or chronic evolution, its special clinical aspect being presented in the moderate suppurative discharge and the tendency to the formation of brownish or greenish crusts, having the odor distinctive of ozena, and justifying the recognition of the condition, not as a complication but as a true manifestation of the implication of the tympanic mucosa in the corresponding intranasal process, and the differentiative title of ozenous otitis. In the cases of prolonged middle-ear suppuration, with recurrent subacute attacks, there is but little in the objective manifestation or in the way of discomfort to the patient, beyond the impairment of hearing, to direct attention to the aural condition, but there is the peculiar ozenic odor of the purulent aural discharge, and objective examination reveals the resemblances, in the ear, to the condition in the nose, in the moderate amount of purulent discharge, and the firm, adherent, malodorous crusts which often resist removal without preliminary softening. The cases reported support in their history the contention of Lannois and Jacod that they present a distinctive class, the recognition of which is a matter of clinical importance. The local, aural treatment employed is that applicable in nasal ozena, the use of mild mentholated ointment and of hydrogen dioxide, for the softening and removal of the crusts, and the subsequent application of the essential oil of birch, the antiseptic quality of which resembles that of the oil of cade, the medium of application being vaseline, with an admixture of from fifteen per cent to twenty per cent of the oil of birch.—*Ex.*

2204**New Method for the Diagnoses of Otitic Tuberculosis.**

F. LASAGNA, *Arch. Ital. di Otol. Rinol. e Laringol.*, March, 1910.

In 1906, Mueller and Jochmann pointed out the proteolytic property of pus. Lasagna uses this in making a cytological and bacteriological examination of several cases of otitis. He determined that the pus from an otitis media containing tubercle bacilli has no proteolytic property while if it contain other micro-organisms it has a very decided proteolytic action.

2208**Roentgen View of the Anatomy of the Temporal Bone in Man.**

R. LEIDLER and A. SCHUELLER, *Arch. f. Ohrenh.*, Bd. 82, Heft 3-4, 1910.

The authors have taken Roentgen views of thirteen normal temporal bones in profile and en face and describe in detail their anatomical findings.

2209**Etiological Relation of Diseases of the Ear, Nose and Throat to Diseases of the Heart, Lungs and Blood.**

R. LEVY.

Original contribution to THE LARYNGOSCOPE, p. 911, Sept., 1910.

2212**Hookworm Disease As It Pertains To The Eye And Ear Specialty.**

L. O. MAULDIN, *Jour. S. C. Med. Ass'n.*, Oct., 1910.

The author discusses theoretically the effects of eye and ear upon the general system. He cites a case of hook-worm disease which improved under eye therapy, and he hopes soon to be enabled to diagnose a case of tinnitus aurium as due to anemia produced by hook-worm.

2214**Present Status of Oto-Laryngology.**

J. F. McKERNON.

Original contribution to THE LARYNGOSCOPE, p. 1107, Dec., 1910.

2216**Aural Tuberculosis in Children.**

W. MILLIGAN, *Jour. of Laryngol., Rhinol. and Otol.*, Oct., 1910.

The author states that in his experience, twenty per cent of hospital children under six years of age, suffering from purulent otitis media owe the origin of the disease to an underlying tubercular infection. The chronic type of the disease is much the more common, and more important from a clinical and practical standpoint. A progressive and extensive necrosis occurs, which leads in time to an exposure of the dura mater, the facial nerve or the contents of the internal ear. The occurrence of the facial paralysis is an early and one might say almost pathognomonic symptoms. There is no other type of middle-ear disease moreover, in which the ossicles are so frequently infected and destroyed.

Certain signs and symptoms make a picture which is unmistakable.

These are the painless onset of the disease, the absence of inflammatory reaction, the frequent presence of two or more perforations, the early appearance of enlarged peri-auricular glands, and facial paralysis.

In a series of tuberculous cases collected by the author facial paralysis was found in sixty-five per cent, whereas in an equal number of non-tuberculosis cases, it was found in only two per cent.

The author thinks children suffering from tuberculous otitis media should be segregated; and he thinks the local authorities should be apprised of the great danger to life from an impure milk supply. WELLS.

2217

International Acumetric Formula Adopted by the Eighth International Otological Congress in Budapest, 1909.

Arch. ital. di Otol. Rinol. e Laringol., Jan., 1910, etc.

Abstracted in *THE LARYNGOSCOPE*, p. 700A, July, 1910.

2220

Entotic Tinnitus Perceivable.

R. L. MOORE, *Jour. A. M. A.*, March 19, 1910.

Patient, aged 30 years, complained of such intense noises in her ear, that she could not sleep. The tinnitus appeared in the eight month of pregnancy. Examination revealed a normal sound-conducting apparatus as well as an intact labyrinth. Six inches from the patient's left ear a fine chirping sound could be heard synchronous with each systole of the heart. It disappeared with pressure on the external carotid. No pathologic lesions or syphilitic history could be ascertained. After delivery the tinnitus entirely disappeared.

2222

Brief Remarks on the Employment of the Roentgen-Photography in Otorhinology. Description of New Chair.

OERTEL, *Passows Beitr.*, Bd. 3, No. 3, 1910.

The chair firmly fixes the patient's head without inconveniencing the patient in the slightest degree. It is minutely described.

The author points out the advantages of the Roentgen rays in anamnesis and clinical examinations, especially in ethmoid and frontal sinus diseases and mastoiditis.

2224

The Exanthemata: Their Causal Relation to Diseases of the Ear.

J. J. PATTEE.

Original contribution to *THE LARYNGOSCOPE*, p. 813, Aug., 1910.

2228

Ganglionic Earache.

A. PUGNAT, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, May-June, 1910.

In three cases of chronic otitis, in which neuralgia of the face and ear was present, the author relieved these symptoms by removing a hard homogeneous ganglion, showing symptoms of acute inflammation, from the tip of the mastoid.

2230**How Far is Heredity a Cause of Aural Disease.**B. A. RANDALL, *Am. Jour. of Med. Sci.*, July, 1910.

Abstracted in THE LARYNGOSCOPE, p. 1106, Nov., 1910.

2231**Study of Sound and Hearing by Means of the Siren.**RANJARD, *Gaz. Med. du Centre*, No. 5, 1910.

The author was successful in seventy-five per cent of his trials. He thus confirms the work of Marage.

2232**Effect of Tobacco on the Ear and Upper Respiratory Tract.**H. O. REIK, *Boston Med. and Surg. Jour.*, June 23, 1910.

Abstracted in THE LARYNGOSCOPE, p. 1009, Oct., 1910.

2235**Osteo-Myelitis of the Temporal Bone.**

C. W. RICHARDSON.

Original contribution to THE LARYNGOSCOPE, p. 1037, Nov., 1910.

2237**The Eye in Diseases of the Ear. (Symposium.)**GILBERT ROYCE, *Can. Prac. and Rev.*, May, 1910.

The searching investigations of a physiological and pathological character made in late years show that direct relationships exist which seem heretofore to have been completely ignored. The author considers that while nerve changes in the absence of evidence of intra-cranial affection have been recorded, it is difficult to believe that a slight meningitis does not co-exist. He has observed blurring of the disc in suppurative otitis, but only in long standing cases. The subject of nystagmus in irritation or disease of the semi-circular canals is fully treated.

WISHART.

2238**Congenital Auricular Fistula.**L. RUGANI, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, Jan.-Feb., 1910.

Report of an auricular fistula in a man and in his three children, evidently hereditary.

2239**Acute Otitis.**E. RUTTIN, *Med. Klinik*, Jan. 2, 1910.

The author divides acute otitis media into two forms, according to its bacteriological causes: 1. Non-capsulated, as streptococcus pyogenes and to this is usually added during the course of the disease the staphylococcus pyogenes aureus. 2. Capsulated as diplococcus pneumoniae and streptococcus mucosa. The course of the non-capsulated form of otitis media is severe and divisible into the typical stages of acute inflammation with bulging drum, perforation with purulent discharge, and lastly, mucous discharge ending with a picture of simple catarrh. However, during its course it may be complicated with mastoiditis.

The picture of the otitis caused by capsulated cocci is entirely different. The onset is slight. The drum shows the same picture as in a serous catarrh. The transparency of the drum is always lost. These slight symptoms remain the same or may become still less but never disappear entirely and may persist for weeks or months. Then suddenly there develops a picture of intercranial complications.

The author then explains the difference between the two groups of otitis and points out the relation the anatomical structure of the mastoid bears to the mode and variety of infection. In conclusion the author states that the non-capsulated streptococci produce severe symptoms at their point of entrance and rapidly develop in the mastoid process together with marked symptoms. The symptoms at the point of entrance also persist. The capsulated cocci on the other hand produce slight symptoms at their point of entry and spread slowly in the bone, and here develop but slight symptoms. They cause exclusive destruction of the bone and usually attention is first called to the action of the bacteria by the involvement of some vital intracranial structure.

KELLY (GOLDSTEIN).

2241

Aural Shock and Mental Disturbances.

SCHAEFER, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Heft 10, 1910.

Schaefer describes the case of an army officer that showed mental disturbances one year after loss of hearing due to the discharge of a cannon. No other cause could be assigned. Analogous to mental shock, following a fall or contusion, and which manifests itself immediately, or latently, the author finds connection between the mental disturbance and the discharge of the cannon and since the literature on this subject is very meager, he presents the case to arouse discussion upon the point in question.

LAWNER (NEUMANN).

2244

The Physiology of Tone-Perception.

G. E. SHAMBAUGH, *Ann. of Otol. Rhinol. and Laryngol.*, Dec., 1911.

A knowledge of the structure of the internal ear is essential in a study of the physiology of tone perception especially because the reaction which results in the transference of a sound-wave to a nerve impulse is a physical one. Fundamental errors have arisen in the discussion of this problem due to the fact that the work has been done by physiologists and psychologists who have not been able to avail themselves of the assistance afforded by first hand anatomical study. Theories have worked out independent largely of anatomical conditions and then the effort is made to fit them to the structure in the cochlea. The problem of tone-perception can best be approached from the standpoint of the anatomist. From anatomical data alone one is able to determine the probable role of the various structures found in the cochlea and thus to establish a fundamental basis for the further discussion of the problem.

It has long been accepted that stimulation of the endings of the auditory nerve in the cochlea is dependent on the physical vibration of a structure in the cochlea in response to the impulse of sound-waves. Phy-

siologists since the time of Helmholtz have been unanimous in placing this vibrating mechanism in the membrana basilaris chiefly because this structure looks like a vibrating mechanism. Now from anatomical data alone it can be shown not only that the membrana basilaris is physically incapable of taking the active role of the vibrating mechanism but that logically it is the membrana tectoria that performs this function. The most important anatomical fact which makes it impossible for the membrana basilaris to fulfill the role of the vibrating mechanism is that this structure has attached throughout its entire extent to its under-surface one or several blood-vessels. These blood-vessels dilating and contracting with varying degrees of blood-pressure, etc., make it impossible for the membrane to respond the same at all times to the same impulse. It is fundamental with all the theories which place the active role in the basilar membrane that this structure responds the same at all times to the same impulse. The conclusion that the membrana tectoria is the logical agent for taking the active role of the vibrating structure is based upon the fact that of the three end-organs found in the labyrinth,—the macula acustica, the crista acustica and the organ of Corti,—in two, the macula and crista acustica, the stimulation is brought about by an interaction between the hairs of the hair-cells and a superimposed structure of epithelial origin,—the otolith membrane and the cupula respectively,—and that this interaction is dependent upon the movement of the superimposed structure. It is rational to assume that in the organ of Corti where the same condition of affairs exists—hair-bearing cells with a superimposed structure of epithelial origin, the membrana tectoria—that here, too, the stimulation of the hair-cells must be dependent upon an interaction between the projecting hairs and the membrana tectoria brought about by vibrations of this membrane in response to the impulse of sound-waves.

The determination of the mode of response which the membrana tectoria gives to the sound impulses must be based upon that response which will best explain the phenomena, pathological and physiological, connected with tone-preception. The most important of these phenomena are: (1) the fact of subjective tone analysis; (2) the occurrence of tone-islands and of defects in the tone-scale associated with disease of the labyrinth; (3) the production of circumscribed defects in the organ of Corti from the over-stimulation by tones of certain pitch. The only response in the membrana tectoria which appears to be capable of accounting for these various phenomena is the response of circumscribed areas of this membrane to impulses of a certain pitch. Two other possible modes of response in the membrana tectoria suggest themselves. One is that the whole of this structure vibrates in response to the impulse of every tone in the scale, the other is that the highest tones produce vibrations in the tectorial membrane near the beginning of the basal coil where this structure is very small, and that every tone lower in the scale will throw into vibration larger and larger areas until the lowest tones which we are capable of hearing will cause the entire membrana tectoria from one end of the cochlea to the other to vibrate. Of the phenomena noted above to be accounted for, subjective tone analysis could be explained by the last method mentioned. None of the other phenomena could be accounted for either by this mode of vibration or by the

vibration of the entire tectorial membrane for each tone in the scale. The conclusion which is forced upon us is that circumscribed areas of the membrana tectoria in the various parts of the cochlea respond to different tones in the scale. Such a response can be accounted for most readily on the principle of physical resonance. The fact that it is impossible to demonstrate such a response is not an argument against this conclusion.

A. A.

2245**Case of Audible Tinnitus.**A. SHARPE, *Lancet*, Jan. 8, 1910.

A man, aged 45, complained of a "scraping noise" in the right ear which began twelve years previously after a chill, and had been constant ever since. Hearing, and appearance of membrani tympani normal. The murmur was heard by an observer's ear placed close to the patient's ear, and very distinctly with the otoscope. It was not unlike a very harsh cardiac murmur, and was synchronous with the pulse. Turning the head to the right modified the sound, and it could be made to disappear by firm pressure over the right carotid artery. Heard with the stethoscope it was very loud, and could be recognized over any part of the head.—*Ex.*

2247**Some Laboratory Aids to Otologic Diagnosis.**F. E. SONDERN, *Ann. of Otol. Rhinol. and Laryngol.*, Sept., 1910.Abstracted in *THE LARYNGOSCOPE*, p. 1179, Dec., 1910.**2249****Tumors of the Acoustic Nerve, Their Symptoms and Surgical Treatment.**M. ALLEN STARR, *Am. Jour. of Med. Sci.*, April, 1910.

A most complete and valuable contribution on a topic of ever increasing importance to the aurist. Dr. Starr first discusses the symptoms characteristic of tumors of the acoustic nerve. They are divisible into three groups: 1. Those referable to the cranial nerves; 2. Those referable to the involvement of the cerebellar peduncles; and 3. Those referable to compression of the tracts passing through the pons. The author then reports with great detail a number of cases. The method of operation and the pathology of the growths is also discussed. PACKARD.

2250**Upper Limit for Air- and Bone-Conduction.**H. J. L. STUYCKEN, *Passows Beitr.*, Bd. 3, Heft 5, 1910.

Minute description of the Schultz monochord which the author has modified.

2251**New Optic Method of Acumetry with Tuning-Fork.**A. STEFANINI, *Arch. Ital. di Otol., Rinol. e. Laringol.*, July, 1910.

The author advocates a method which is not as complicated nor as costly as that of Struyken or Quix and which enables the optic acumetry to be prolonged far more than by Gradenigo's method.

2254**Suppurative Ear Diseases in Diabetes Mellitis.**

O. J. STERN.

Original contribution to THE LARYNGOSCOPE, p. 731, July, 1910.

2259**Pain-sensation in the Region of the Ear.**E. URBANTSCHITSCH, *Klin. Therap. Wchnschr.*, Jan. 24, 1910.

Urbantschitsch discusses the pains met with in the ear as produced by four groups of causes; inflammation; irradiation from the teeth, the nose, the throat, the eye, and other parts of the body; neurotic, including diseases of the vascular system, infectious diseases, intoxications with mercury, lead, etc., general nervous diseases, diseases of metabolism and rheumatism; and traumatic.—*Et.*

2261**Notes on the Auditory Conduction-Apparatus of Hungarian Rodents.**VALL, *Passows Beitr.*, Bd. 3, Heft 5, 1910.

Minute description of the bulla, auditory canal, tympanum, and ossicles in the Hungarian rodent.

2267**Oto-Laryngology Abroad.**D. J. GIBB WISHART, *Can. Lancet*, Feb., 1910.

The writer gives a brief account of his visit to the Throat Clinics in Naples, Rome, Freiburg, Munich, Vienna, and Heidelberg, Cardiff and Glasgow, in 1908, describing at some length the facilities provided for work in each place, with especial emphasis upon Rome, Freiburg and Heidelberg. Attention is drawn to the advantages which the clinic of Prof. Ferreri in the Polikliniko in Rome, places at the disposal of the post-graduate worker, and to the advanced position held by oto-laryngology in Italy, a fact much overlooked by the visitor to Europe, probably due to ignorance of the language, and quotes de Carli in the *Archives Internationales de Laryngologie de Paris*, who asserts that the Clinic in Rome is provided with everything which is useful in the diagnosis and treatment of diseases of the throat, nose and ear. A. A.

2272**The Rhodan Reaction of the Parotid Saliva in Diseases of the Ear.**G. ZICKGRAF, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61, Heft 3-4, 1910.

Zickgraf tested in one hundred and six cases Juergens' investigations on the significance of the Rhodan reactions. He quotes Juergens' conclusions.

2274**The Role of Teachers, Parents and School Physician in the Ear-Hygiene of School-children.**G. ALEXANDER, *Monatsschr. f. Ohrenh.*, Vol. 44, p. 1155, 1910.

From his experience as special school inspector, Alexander concludes as follows:

(1) The effective work of the school otologist demands a knowledge of ear hygiene on the part of teachers and parents.

(2) At stated periods the school inspector or other officer should deliver lectures on hygiene with special reference to the hygiene of the ear.

(3) In larger cities the school inspector should deliver lectures upon the hygiene of the nose, throat and ear, to which the pupils should be admitted.

(4) The school inspector should refer all cases of disease of the nose, throat and ear to the school otologist.

(5) The otologist should examine the children in the presence of the school inspector and of the parents.

(6) It should be expressly stated that such examinations are not obligatory.

(7) The otologist makes the examination and diagnosis and outlines the treatment.

(8) Conservative treatment is left to the family physician after consultation with the otologist and school inspector, and occasionally with the teacher.

(9) Operations are performed by the school otologist after the consent of the parents has been obtained by the school inspector or family physician.

(10) In popular lectures to the parents, the school inspector should emphasize the importance of the hearing for the instruction and intelligence of the child.

(11) A tract should be published in which all facts relating to the hygiene of the ear are clearly stated, and distributed to pupils, parents and teachers.

YANKAUER.

2275

Treatment, Course and Prognosis of Purulent Affections of the Labyrinth.

G. ALEXANDER, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, Jan.-Feb., 1910, and *Arch. f. Ohrenh.*, Bd. 82, Heft 1-2, 1910.

Alexander divides labyrinthitis into acute and chronic, serous and purulent according to its nature; into pari-peri- and endo-labyrinthitis according to its localization; also into circumscribed and diffuse.

Treatment is discussed under two heads—conservative and operative. Acute, serous labyrinthitis and sub-acute circumscribed labyrinthitis are treated by conservative measures. Vertigo and spontaneous nystagmus are treated by absolute rest in bed extending over a period of weeks until these symptoms subside.

Bromides are prescribed internally. The operative treatment is fully discussed. Much recent clinical data and experience afford better conclusions as to indications for operation.

Lumbar puncture should always be performed as it affords data of intra-cranial contents and also reduces the risk of the post-operative spread of the infection by lessening endo-cranial tension. The author formulates the following empirical rule: "In all cases of purulent laby-

rinthitis where operation is decided upon, this should extend to the internal as well as to the middle-ear spaces. To perform the radical mastoid operation alone is to run a great risk of propagating the infection from the labyrinth to the intra-cranial structures."

The technic of various methods of the labyrinth operation is reviewed and the author's own method described. He insists that dura of the middle and posterior fossi should be freely exposed in every case of extended operation on the labyrinth; so that extra-dural abscess, empyema of the sacculus lymphaticus may not be overlooked and the operator be placed in a better position to recognize intra-cranial infections should they arise. The post-auricular wound should not be closed for a time.

Prognosis is favorable in uncomplicated cases, those depending on the form of labyrinth suppuration present. In the majority of cases children operated on for labyrinth suppuration die eventually of tuberculous meningitis. In this class of cases, therefore, the prognosis is grave.

GOLDSTEIN.

2277

Urotropin in Otitis.

W. M. BARTON, *Jour. A. M. A.*, March 12, 1910.

Fifteen grains of urotropin were internally administered in divided doses in suppurating otitis media. The discharge was at once lessened and ceased after a repetition of the dose. A decided hexamethylenamin reaction appeared in the discharge showing that elimination by the aural mucosa took place.

2282

Treatment of Otitis Media

J. BOULAI, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, March-April, 1910.

For acute otitis media Boulai recommends cold applications, frequent and for long intervals with compresses over the whole region and antiseptic drops instilled in the ear. For chronic otitis he recommends a slightly altered technic.

2283

New Contribution to the Operative Technic of the Labyrinth.

BOURGUET, *Jour. of Laryngol., Rhinol. and Otol.*, Aug., 1910.

Procedure by which the vestibule is laid open behind, by following posterior branch of horizontal canal, above by opening the two ampullary orifices of the two canals, external and frontal; and below by throwing the round and oval windows into one.

2284

Hexamethylenamin in Suppuration of the Middle-Ear and the Nasal Sinuses.

E. J. BROWN, *Jour. A. M. A.*, April 16, 1910.

Brown reports a case of otitis in a woman of 26 years cured by the use of five grains of hexamethylenamin three times a day. In a case of chronic maxillary sinusitis he obtained the same favorable result.

2285**Opsonic Therapy in Suppurative Infections of the Ear and Nasal Sinuses.**

C. CALDERA, *Arch. ital. di Otol., Rhinol. e Laringol.*, Sept., 1910.

Caldera introduces his article with some general notions on vaccine therapy and then adds the results of sixteen cases, carefully studied. He holds it to be of no value in cases of bone lesion. In acute or chronic cases it is somewhat useful. But it gives most satisfactory results in exclusively acute cases.

LASAGNA.

2289**Vaccines in Acute and Chronic Otitis Media.**

A. C. CHRISTIE, *Jour. A. M. A.*, Feb. 26, 1910.

Report of six cases in which vaccines made of the organisms found in a bacteriological examination of the pus have produced excellent results. Vaccine should not, however, exclude local treatment.

2293**Value of Phlebo-Narcosis in the Surgery of the Upper Air Tract and of the Ear.**

G. FERRERI, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, May-June, 1910.

Chloro-phlebo-narcosis is an ideal anesthesia in the surgery of the ear and upper air tract if one does not fear that the injection may provoke a hemorrhage capable of exaggerating the operative difficulties in intracranial complications and especially in thrombo-phlebitis in that it favors the formation of a hemorrhage. It cannot be used in tracheotomy. However, in operative intervention in the sinuses, ear, nose, pharynx and larynx it may be of great service.

2295**Use of Scarlet Red in Treatment of Discharges.**

GAUDIER, *Ann. de Mal. de l'Oreille, du Larynx du Nez et du Pharynx.* April, 1910.

The author recommends post-operative treatment with five per cent scarlet red, with which he has achieved rapid healing. The maximum period being seven weeks.

2296**Cosmetic and Plastic Surgery of the Ear.**

M. A. GOLDSTEIN, *Arch. ital. di Otol., Rinol. e Laringol.*, Jan., 1910.

Original contribution to *THE LARYNGOSCOPE*, p. 826, Oct., 1908.

2297**Suction in Suppurative Otitis.**

H. GRADLE, *Trans. Chicago L. and O. Soc.*, March 22, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1170, Dec., 1910.

2298

Vaccine Therapy in Serious Infections of Aural and Nasal Origin.

C. GRAEF and R. B. WYNKOOP, *New York Medical Journal*, July 9, 1910.

The authors record in detail two cases successfully treated by vaccines. The chief interest arises from the fact that in one, a clearly established case of septic thrombosis of the lateral sinus, recovery was secured without excision of the jugular vein, while the other is, so far as the authors are aware, the first recorded case of meningitis, due to streptococcus infection, cured by vaccines.

Case 1. A boy of 12 years, had suffered from an acute suppurative inflammation of the right middle ear for some weeks, when he developed severe mastoiditis, and was admitted to hospital for immediate operation. On opening the mastoid, widespread necrosis of the bone with much pus was found. On exposing the lateral sinus, pus was seen oozing from between the bone and the membranous wall. The diseased bone having been thoroughly removed, the sinus was opened, and found to be free of obstruction and seemingly clean. The wounds were packed in the usual way. Within two days the temperature had fallen from 103° to normal, but the patient complained of marked tenderness along the track of the jugular vein on the right side of the neck, and, later in the day, severe pain developed in the abdomen in the region of the appendix. A diagnosis of acute appendicitis was made, and the patient was operated on immediately. The appendix was found to be full of pus, tightly distended, and on the point of rupture. It was felt that the child was too ill to be subjected with safety to the added shock entailed by dissecting out the internal jugular vein, although the step was indicated by the signs of a developing thrombosis and the certainty that infection of the blood-stream must follow. It was determined instead to watch for blood infection, and make use of vaccines as a remedy. The pus in the appendix showed bacillus coli communis only. A week after appendectomy, streptococci in pure culture were obtained from the blood. Metastatic inflammation had appeared in the right shoulder and elbow, and, a few days later, an abscess developed on the dorsum of the right foot, from which the streptococcus was obtained in pure culture. The same organism was found on packing taken from the infected sinus. As soon as a positive blood culture was obtained, treatment by a stock streptococcus vaccine was instituted, and three days later this was replaced by autogenous vaccine. Daily doses of 10 millions were given for a week, and thereafter the doses were increased by 3 millions daily until a 25 million dose was reached. By this time the temperature had fallen to normal, and the vaccine was thereafter given only twice a week. Patient left hospital fifty-six days after admission, having received altogether twenty-three doses of vaccine, aggregating 413 million organisms.

Case 2 was that of a woman of 24 years, suffering from nasal obstruction and muco-purulent catarrh, who, within a few days of operation for deflected septum, developed well-marked signs and symptoms of acute meningitis. Fluid obtained by lumbar puncture ten days after the operation yielded a pure growth of streptococcus. An autogenous vaccine was at once made, and administered in daily doses of 10 millions for a period

of five days. The dose was then increased by 3 millions daily until the 25 million mark was reached. This amount was then given for five days, after which the same amount was given twice a week. The patient was discharged thirty-eight days after admission to hospital. In all, she received seventeen doses, amounting to 323 million organisms. The nasal septum had healed without trouble.

In neither case was an estimation of the opsonic index made, the dosage was taken arbitrarily, and modified to suit the needs of the individual cases as shown by the clinical symptoms. The charts of both cases are appended.—*Ex.*

2304

Local Anesthesia in Ear Surgery.

J. J. HURLEY, *Boston Med. and Surg. Jour.*, March 24, 1910.

Hurley speaks of Neumann's, of Vienna, method of local anesthesia in ear surgery. Neumann, acting upon Heidenheim's suggestion, in 1904 operated in a case of simple mastoiditis, anesthesia being brought about by the subperiosteal injection of a one per cent solution of cocaine plus adrenalin. The result was all that could be desired. Since that time, and with improved technic this method has been a routine procedure at the Poltzer clinic whenever it was indicated. Having demonstrated the value of the anesthesia, Neumann undertook a series of experiments to ascertain how it was brought about. By the subperiosteal injections of the frontal sinus of rabbits with a solution of cocaine and adrenalin, to which had been added a few drops of gentian violet, he found that, upon going in the layer of periosteum next to the bone, the cortex itself and, upon opening the cavity, the mucous membrane lying along the vessels, had taken on an intense violet color. The same thing obtained in experiments on living subjects. The anesthesia is brought about by the absorption of the fluid through the bone canals and lymph spaces until it comes to lie along the vessels and nerves, anesthetizing at one and the same time soft parts, bone, and mucosa. Contra-indications are only two in number: 1. Cases in which there exists a subperiosteal abscess. In these cases there is not enough pressure to cause the necessary absorption, and most of the fluid escapes at the needle opening. 2. Very neurotic persons, not because the anesthesia is not sufficient, but because of the psychic effect of consciousness. Indications are: In all cases of lowered vitality, advanced pulmonary tuberculosis, acute lung affections, diabetes, nephritis, in short, in all cases in which there is a contra-indication to general anesthesia. The present solution, and the standard, now consists of five cc. of a one per cent solution of cocaine plus twelve drops of adrenalin plus three cc. of physiological salt solution. The salt solution is added to increase the amount of fluid. This increases the pressure. While the relative strength of the solution is diminished, the absolute amount of cocaine remains the same. This solution is heated to body temperature, but must not be boiled.—*Ex.*

2305

Vaccine Therapy in Chronic Otitis Media.

P. A. JACOBS, *Cleveland Med. Jour.*, Feb., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 566, May, 1910.

2310**Scharlachrot and its Cicatricial Properties.**

LEMAIRE, *Echo Med. du Nord*, June 12, 1910.

Report of the successful use of scharlachrot in thirty-one cases. The amount of irritation is always very slight and quickly disappears as soon as the applications are discontinued. One should apply the scharlachrot during twenty-eight or forty-eight hours and then cleanse the wound and apply lanoline for twenty-eight hours and then again use the scharlachrot. By this procedure aseptic results are obtained, as the salve itself has only slight aseptic properties. In case of sepsis salicylic acid may be used as a wash.

2312**Some Observations on the Treatment of Chronic Purulent Otitis Media.**

C. C. McCULLOUGH, *Dom. Med. Monthly*, April, 1910.

Is the tympano-mastoid operation as performed so frequently in America after all a cure for persistent purulent aural discharge? Reference is made to the remarkable percentages of cures obtained by Bezold's boracic acid treatment as recorded by Ruppert. The author distinguishes between a dangerous and a non-dangerous type of persistent aural purulent discharge, and believes that an investigation of his case-reports distinctly favors the correctness of Heath's theory regarding the antrum as the focal point in the maintenance of the disease process. Where actual bone disease cannot be demonstrated the author believes surgical procedures unnecessary.

WISHART.

2313**The Use of Adrenalin Chloride in Special Work on the Eye, Ear and Throat.**

MURRAY MCFARLANE, *Can. Lancet*, March, 1910.

The notes from observations were made while experimenting eight years ago on behalf of Parke, Davis & Co. Pain was occasionally noticed in the nose and face when a solution of 1 to 1000 was painted on the turbinates, and in three cataract extractions it seemed to cause a profuse hemorrhage from the iris when iridectomy was done. The author uses a 1 to 1500 solution with five per cent of chloretone in removing adenoids, and gives no general anesthetic except in case of very small children. Adrenalin applied in normal saline solution is almost without irritation.

WISHART.

2316**Results of Vaccine Therapy in Chronic Suppurative Otitis.**

E. W. NAGLE, *Trans. Am. L. R. and O. Soc.*, April, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 48, Jan., 1911.

2318**After-Treatment of Middle-Ear Exenteration.**

R. PANSE, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61, Heft 2, 1910.

Panse advocates the use of the tamponade after radical operation of the middle-ear. He refutes each of the objections raised against this

method. The author warns against an indiscriminating use of his plastic; he himself never applies it in dura or sinus exenteration or in children under ten years.

2320

Technic of Autopsy and of the Macro- and Microscopic Examination of the Ear.

POUGET, *These de Bordeaux*, 1910.

Pouget expounds the two methods of aural autopsy, which he considers the most simple—a macroscopic and a microscopic technic. As a type for a macroscopic examination the author takes an otitic cerebral complication and points out what, why and how to examine the auditory organ.

Under macroscopic technic attention is called to the histological examination of the ear. He treats of the fixation of the petrosa, its decalcification, its inclusion and the coloring of the sections. He also gives a resume of the two technics known, that of Katz and that of Wittmack. The article is of exceptional interest and value.

2321

Treatment of Eustachian Tube in Chronic and Recurrent Otorrhea.

S. S. PREOBRASCHENSKI, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 62, Heft 3-4, 1910.

Inflammatory changes in the Eustachian tube are not always improved after treatment of the tympanic cavity and are responsible therefore for the continued otorrhea.

These changes may consist of suppurations in any part of the tube, other inflammatory reactions or simply circulation disturbances there.

Tubal changes are usually latent in character and may only be discovered after passing the bougie.

Protracted, fetid secretions are possible not only in the attic and antrum but also in the Eustachian tube. The inflammatory processes in the tube do not necessarily disappear with the cessation of the otorrhea and therefore recurrence of otorrhea is not only dependent on unhealed perforations of the M. T. or of the condition of the nose, but is frequently also the result of remaining tubal changes.

In many cases the Eustachian tube required no special attention in the treatment of otorrhea. If after one to two months' treatment of the tympanic cavity and careful attention to the nose and pharynx, no marked results are obtained in the otorrhea, the conclusion is justifiable that the tube is a responsible factor and special treatment should be undertaken. The author emphasized the value of vibration-massage which he employs in connection with a metal concha devised by him. The use of bougies with or without medication and air inflation are also mentioned.

GOLDSTEIN.

2324

Vaccine Therapy in Otology.

B. A. RANDALL.

Original contribution to THE LARYNGOSCOPE, p. 869, Sept., 1910.

2325**Vaccine Therapy in Otology.**

H. O. REIK.

Original contribution to THE LARYNGOSCOPE, p. 860, Sept., 1910.

2327**A Point in the Use of Nitrate of Silver in the Treatment of Chronic Suppurative Otitis Media.**G. L. RICHARDS, *Boston Med. and Surg. Jour.*, Sept. 8, 1910.

The author advocates the following method: Cleanse the suppurative area by syringing, suction, wiping, and removing all polypi and debris. Enlarge small perforation if need be. Lay patient's head over so that affected ear lies uppermost and horizontal. Instil nitrate of silver solution to fill canal and allow to remain five minutes, then wipe out and insert light wick of cotton or gauze; begin with three per cent solution, increasing gradually to twenty per cent if necessary. Repeat every other day to once a week.—*Ex.*

2328**Auditory Re-education by Means of the Electrophone.**ROURE, *Bull. de la Soc. Chir. de la Drome*, Oct., 1910.

The author cites five instances in which much improvement was effected. The greatest benefit is obtained in young people.

2329**Method of Correcting Protruding Ears and Closing Retro-auricular Sinuses.**E. RUTTIN, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 2, 1910.

For the correction of protruding auricles, Ruttin constructs a flap of the skin of the posterior surface of the auricle, which he super-imposes over a similar shaped area denuded of skin over the mastoid process. The same technic is also used by him for the closure of retro-auricular fistulae.

GOLDSTEIN.

2332**Scharlachrot in the Treatment of Perforations in the Tympanic Membrane.**A. SCHISCHO, *Wratschebnaja Gazeta*, No. 1, 1910.

A five per cent scharlachrot solution, applied in four cases, produced absolutely no irritation. A lengthy application, however, produced no result.

2336**Treatment of Acute Purulent Middle-Ear Inflammation with Bier's Hyperemia Method.**SPIRA, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Vol. 44, 1910.

Cases are cited in which this method was successfully used. The author warns against its use in the presence of intra-cranial complications.

2337**Use of Scarlet-red Salve in Ear Diseases.**

C. STEIN, *Monatschr. für Ohrenh. u. Laryngo-Rhinol.*, No. 2, 1910.

Stein records his experiments with scarlet-red salve in diseases of the ear and recommends its use (eight per cent) because of its tendency to reduce secretions and especially its favorable action toward epidermization after radical operations in such cases where small portions fail to heal over. In cases where secretions increase after application, its use is contra-indicated. The salve should be applied daily for two days, then the dry insufflation method pursued for 24 hours, then again applying the salve for two days. Ear should be thoroughly cleansed before its use, and all polypi or large granulations removed. Chronic suppuration of the mucous membrane of the middle ear is often mitigated by the use of this salve.

GOLDSTEIN.

2238**Use of the Wire-Saw in the Radical Operation on the Middle-Ear.**

S. STEIN, *Dan. Klinik.*, p. 953, 1910.

The wire-saw is composed of two steel wires twined together. They are 25 mm. in thickness.

KIAER.

2340**Picric Acid in the Treatment of Perforations of the Tympanum.**

R. STEVANI, *Bol. delle Mal. delle Orecchio, della Gola e del Naso*, May, 1910.

The author strongly recommends the use of picric acid for perforations and gives the formula.

2345**Auditory Re-education by Electro-Voice Phonetics.**

A. ZUND-BURGUET, *Arch. internat. de Laryngol. d'Otol. et de Rhinol.*, July-Aug., 1910.

The author is of the opinion that in cases of progressive deafness, re-education of the aural function can best be accomplished by oral exercises—but since this is extremely trying upon the voice and since one and the same voice cannot well be used for high and low sounds, he has perfected an apparatus which reproduces the human voice, low and high tones of varying intensity. This apparatus can be used by two patients simultaneously.

GOLDSTEIN.

2346**An Irregularly Pearl-shaped Bone Formation in the Mastoid Process.**

E. AMBERG, *N. Y. Med. Jour.*, Oct. 8, 1910.

The above-mentioned anatomy was found during a mastoid operation upon a female, 41 years of age, following a grippal infection. The patient later succumbed to an intradural abscess and meningitis, with symptoms of an abscess in the right motor region, (autopsy): This pearl-like bone formation (illustrated) was apparently attached by small stem and showed a minute sharp point. It measured 3.5x3. or 2.5 mm. It was found in the diploetic structure, and might have been dislocated from the inner wall of the cortex, by the chisel.

LEDERMAN.

2347**Syphilitic Mastoiditis.**

F. ARDENNE, *Rev. hebdomadaire de Laryngologie, d'Otologie et de Rhinologie*, March 12, 1910.

Abstracted in THE LARYNGOSCOPE, p. 757, July, 1910.

2348**Why the Failure after Radical Mastoid?**

J. F. BARNHILL, *Annals of Otology, Rhinology and Laryngology*, March, 1910.

Unsuccessful radical mastoid operations may be due to anatomical anatomy of the osseous structure, to bad asepsis during or after the operation; to faulty technic or incomplete operation; or to the post-operative dressings.

2349**Comparative Merits of Methods Employed in the Various Mastoid Operations.**

J. C. BECK.

Original contribution to THE LARYNGOSCOPE, p. 515, May, 1910.

2351**Dermoid Cyst of the Infected Mastoid Resembling Mastoiditis.**

BONZOMS, *Archiv für Internat. de Laryngologie, d'Otologie et de Rhinologie*, March-April, 1910.

Woman, 31 years old, suffered since a week from slight fever, insomnia, cephalagra and anorexia. The left mastoid was inflamed and swollen. At the age of 11 years the patient had had a tumor on this mastoid which had been cauterized. The auditory canal and tympanum were normal, and her hearing good. A cyst the size of a pigeon's egg was removed containing hair, fat and pus. Recovery.

2358**Malignant Tumors of the Mastoid Region.**

C. BRUZZONE, *Archiv ital. di Otologia*, March, 1910.

1. Man, aged 59 years, had a large polymorphic-celled sarcoma, which was removed, then radiotherapy was applied. Cure.

2. In a child of 6 years a carcinoma was locally treated with trypsin injection and the Roentgen ray applied. Cure.

The author concludes that operative treatment should always, when possible, be added to that with the Roentgen rays in dealing with malignant tumors.

2359**A Case of Fatal Mastoiditis, Showing no Classical Symptoms for 13 Days Before Death; Death Due to Secondary Thoracic Complications of Mastoiditis.**

W. SOHIER BRYANT, *Archiv international de Laryngologie, d'Otologie et de Rhinologie*, Sept.-Oct., 1910.

Patient, a woman 63 years old. First seen, February 4. Temperature 98.4°, pulse 80, respiration 20. Right otitis media and bloody discharge. Otherwise physical condition negative. No change until February 13,

when temperature suddenly rose to 102.8°. On right, considerable mastoid tenderness and edema; edema of canal. Wide perforation of tympanic membrane. Discharge largely bloody. Left ear showed opaque, flat, thick membrane.

Condition remained practically unchanged until February 25, when tenderness and swelling about right mastoid region had disappeared, only slight discharge remaining. From February 25 to March 10, day of death, the only symptoms noted were weakness and temperature of 97°, pulse 80, respiration 20.

Autopsy showed cause of death to be secondary thoracic complications. Anatomical findings were: purulent double otitis media and mastoiditis. Left membrana tympani imperforate. No perforation of bony walls of either tympanum. Veins and sinuses normal. Acute pericarditis. Acute purulent bronchitis. The same streptococcal organisms were found in the bronchitis, the pericarditis, and otic lesions.

All classical symptoms of mastoiditis were absent for thirteen days before death. The history of the case offers a strong argument against being misled by apparent convalescence from mastoiditis, and indicates that immediate operation is demanded when the involvement of the mastoid first becomes evident.

A. A.

2364

Case of Primary Mastoid Periostitis.

W. P. COUES, *Jour. Am. A.*, June 25, 1910.

Girl, 20 years old, had retro-auricular abscess probably of glandular origin. Deep incision of swelling revealed no pus; free bleeding. As little relief was obtained, a second operation was performed. The incision was enlarged and a deep cervical abscess opened. Pressure on the mastoid increased the flow of pus. Third operation: The incision was carried to the mastoid; the bone was laid bare but no necrosis was detected. The incision was drained and a tube was also left in the neck. Recovery was rapid.

2367

Suppurative Adenitis Under the Sterno-cleido-mastoid Muscle Treated with Streptococcus Vaccine.

F. O. DE BEECK, *Med. Rec.*, Sept. 17, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1146, Dec., 1910.

2369

Case of Double Mastoiditis Showing Symptoms of Intracranial Involvement. Recovery without Opening the Cranial Cavity.

L. EMERSON.

Original contribution to *THE LARYNGOSCOPE*, p. 85, Jan., 1910.

2372

Mental Aberration Following Mastoid Operation.

H. GIFFORD, *Western Med. Rev.*, Jan., 1910.

The first patient was a woman of 65, with a double mastoiditis following acute otitis media during attack of grippe. Both mastoids were opened, and considerable pus was evacuated from each. The patient made an

ordinarily rapid recovery without any unusual objective symptoms, but following the operation she seemed to be in a somewhat dazed condition, and at the end of two weeks, when her mind seemed to be entirely normal again, it was found that the entire period from the day preceding the operation to the end of the two weeks was a perfect blank so far as she was concerned. She had absolutely no recollection of the operation, nor of the preparations for it, nor of anything that had occurred in the meantime. In other respects there was nothing unusual about the case. her mind became entirely normal and she made a good recovery. The second patient, a man, within twenty-four hours after the operation showed decided signs of mental aberration and became unruly and very talkative; and in the course of the next day or two became a furious maniac; so entirely unmanageable that he had to be put in a strait-jacket and confined to a cage bed in which he could thrash about without injuring any members of the hospital staff. By rubbing his head about he made any attempt at dressing the wound entirely useless, but nevertheless it progressed beautifully, and his ear gave him no further trouble. His mental condition, however, showed so little signs of improvement that he was removed to the state asylum, where at the end of about two months after the operation, he recovered entirely. He returned to his business and had no further relapse, either mentally or orally. The third patient, a woman, presented plain symptoms of mastoid abscess and Gifford performed a radical operation, removing much pus and old cholesteatomatous masses from the antrum and adjoining cells. One week after the operation, she became semicomatose, with a slow pulse and nearly normal temperature. The symptoms of brain abscess were so marked that Gifford at once removed the roof of the antrum and of the tympanic cavity and exposed the dura for a space one inch by one-half inch in extent. An incision into the brain immediately above the tympanic cavity gave no result, then an incision up and slightly back one inch posterior to the auditory canal opened a brain abscess from which about three drams of pus was evacuated. A glass drainage tube was inserted into the cavity and the rest of the wound dressed with iodoform gauze. The woman improved rapidly and so that as far as the ear and brain wounds were concerned the cure was complete, although she developed an apparently permanent paralysis of the right third nerve; but her mind never became perfectly clear and gradually symptoms of profound melancholia with delusions developed, which have persisted up to the present time, that is, for nearly a year after the operation.—*Ex.*

2375

Sensory System of the Facial Nerve and Its Symptomatology.

J. R. HUNT, *Arch. Internat. de Laryngol., d'Otol. et de Rhinol.*, Jan.-Feb., 1910.

The author holds that all sensory disturbances at the time of, or previous to facial paralysis are the result of affection of the sensitive portion of the facial nerve. Thus reflexly the spastic facial cramps are discharged.

2376**Opening of the Antrum and the Radical Mastoid Operation Under Local Anaesthesia.**

N. JONES, *Can. Jour. of Med. and Surg.*, Aug., 1910.

The author reviews the literature of the subject and gives the details of the methods pursued by Neumann from personal observation. Local anaesthesia is contra-indicated where a sub-periosteal abscess exists and in nervous patients but is suitable in all cases of failure of compensation, advanced pulmonary tuberculosis, acute lung affection, and diabetes or nephritis.

A good meal is given first. The solution consists of 5 ccm. of 1 per cent cocaine, 12 drops of adrenalin, and 3 ccm. of physiological salt solution, warmed but not boiled. The injection is made directly over the bone, under the periosteum. The anterior surface of the mastoid process must be carefully cocaineized. In the hands of Neumann the operation with the exception of the curetting of the Eustachian tube was quite painless, and the patients laughed and chatted. WISHART.

2379**Mastoiditis With Meningitis.**

P. LAMOTHE, *Prensa Med.*, March 15, 1910.

Case in man 37 years old having a chronic otitis media of long standing. In the course of an attack of grip a mastoiditis appeared with symptoms of meningitis. An antrotomy was performed. Recovery.

2382**Stereoscopic Mastoid Radiograms.**

S. LANGE.

Original contribution to *THE LARYNGOSCOPE*, p. 437, April, 1910.

2383**Unusual Case of Pharyngeal Abscess in Mastoiditis.**

F. LASAGNA, *Arch. Ital. di Otol., Rinol. e Laringol.*, March, 1910.

In this case the pus from the mastoid penetrated into the region between the styloid process and the mastoid and pushed itself into the pharynx posterior to the inferior maxilla. Pus could be traced up to the alae pterygoideae of the sphenoid sinus. The prognosis in these cases is always grave.

2387**Mastoiditis in Infants.**

G. W. MATHEWSON, *Dom. Med. Monthly*, Sept., 1910.

The author refers to the diversity of opinion among anatomists as to the time at which the air cells appear in the mastoid region, the more recent writers granting that there is a mastoid process at the end of the first year, and points out that some mastoid processes are never pneumatic, but remain diploetic. "In all the cases to which the author refers there was within the cortex cancellous bone, and in some of them the spaces were as large as in some adult mastoid bones."

During the past two years the author has operated upon fourteen mastoids in a series of ten patients whose ages varied from four months to twenty months, in ten of which streptococcus was found in pure culture. The cases uniformly occurred in Jewish children. WISHART.

2393

Dehiscence of Facial Nerve.

POUGET, *Gaz. Hebd. des Sci. Med. de Bordeaux*, Aug. 7, 1910.

Presentation of histological preparations and photographs of the petrosa. The author uses a decalcifying process by which he has accomplished complete dehiscence of the facial nerve.

2394

Enormous Sequestrum of Mastoid Following Otitic Measles.

RABASSA, *Rev. barcelonesa de Enfermad. de Oido*, No. 18, 1910.

The sequestrum encompassed the cortex of the process and occupied the outer plane from the base to the tip, as well as a large part of the posterior upper wall of the auditory canal. Operation. Recovery.

2396

Erysipelas as a Complication of Mastoid Disease.

G. L. RICHARDS.

Original contribution to *THE LARYNGSCOPE*, p. 997, Oct., 1910.

2399

The Toilet of the Tympanum and its Relation to the Success of the Radical Mastoid Operation.

GILBERT ROYCE, *Dom. Med. Monthly*, Oct., 1910.

This article appeared in another journal in 1909 and was then excerpted.—(*THE LARYNGSCOPE*, p. 158, Feb., 1909.)

2415

The Radical Mastoid Operation and its Technic.

D. J. GIBB WISHART, *Can. Jour. of Med. and Surg.*, Feb., 1910.

The paper sets forth in detail the methods of operation pursued personally by the writer. A preference is expressed for the Alexander modification of the Klar Electric Head Light as an illuminant possessing many distinct advantages—having little weight, giving absolutely no heat, and admitting of focal adjustment to suit the operator. Thorough illumination is urged as a necessity in making the deeper dissections. WISHART.

2416

Guide for the Lateral Sinus.

E. AMBERG, *Med. Record*, Oct. 23, 1910.

The instrument offered is pictured and described. It consists of two shanks and a handle. One shank should be held over the anterior border of the mastoid process, the other over the temporal line. The handle of the guide gives the direction of the lateral sinus line. LEDERMAN.

2418**Abnormal Dilatation of Jugular Fossa on Floor of Tympanic Cavity with Occlusion of Round Window of Ear.**

H. BEYER, *Passows Beitr.*, Bd. 3, Heft 5, 1910.

Description of a temporal bone in which an extensive enlargement of the tympanic cavity proved to be the roof of a vesicular protrusion of the jugular fossa.

2419**Two Unusual Cases of Otitic Sinus Thrombosis; Operation; Recovery.**

H. B. BLACKWELL, *N. Y. Med. Jour.*, Feb. 5, 1910.

Report of two atypical cases both aged six years. In the first case the only symptoms were ear discharge for six years, pain in head and throat and a chill. Entire recovery was obtained by excising the jugular bulb throughout its entire length. In the second case there was an extensive clot of blood in the lateral sinus. Only symptom was earache. Right jugular vein was excised.

2422**Case of Sinus Thrombosis Complicated by Cerebral Abscess and a Purulent Leptomeningitis.**

A. BRAUN, *Med. Rec.*, March 26, 1910.

Man, 58 years old, complained of pain in right ear, and right side of head. The tympanum was red, thick and perforated giving passage to pus. Edema of the posterior superior wall of the canal and tenderness on mastoid. Temperature, 102° F. No chills or fever. Antrotomy was performed. Three days after operation, violent headache in the right occipital region. The symptoms became more serious and a lumbar puncture was made by which much pus and Friedlaender's bacilli were found. Death on following day. Autopsy: Pia-mater bathed in pus; generalized purulent lepto-meningitis; abscess of right lobe of cerebellum containing fetid pus.

2423**Two Cases of Abnormal Position of Lateral Sinus.**

BRUNETTI, *Rev. veneta di Sci. med.*, May 31, 1910.

In one case the sinus was discovered at the base of the mastoid completely filling it and in contact with the posterior wall of the bony canal. It was entirely normal. In the other case the sinus groove was very much developed and was buried deep in the posterior portion of the temporal bone and thus entered mastoid. The external cortex formed its outer wall.

2424**Thrombosis of Lateral Sinus. When to Operate; What Type of Operation to Choose.**

E. A. CROCKETT, *Ann. of Otol. Rhinol. and Laryngol.*, June, 1910.

The author recommends operation to relieve thrombus in all cases of acute or chronic otitic suppuration presenting rapid variations of temperature for more than three days, especially with chill, headache, vomiting, malaise, and increasing leucocytosis without waiting for

symptoms of otitic septicemia. This is particularly urgent where in a former operation, the sinus has been accidentally opened or the existence of a peri-sinus abscess found. The author then discoursed on the various types of operation.

2427

Sinus Thrombosis of Otic Origin and its Relation to Streptococemia.

E. GRUENING, *Ann. of Otol., Rhinol. and Laryngol.*, March, 1910.

Detailed report of two cases showing the possible course of the disease. The diagnosis of sinus thrombosis was reached from the clinical symptoms alone, but the author feels that a positive blood-culture is of important service in ascertaining the presence of a thrombosis.

2431

Report of Two Cases of Lateral Sinus Thrombosis Treated Post-operatively With Hiss' Extract of Leucocytes.

S. McCULLAGH.

After explaining what this extract is and the manner of preparing it, the author cites two instances in which it was used with very satisfactory results.

2432

Operative Interventions on the Jugular Bulb.

E. J. MOURE, *Rev. hebdomadaire de Laryngol., d'Otol. et de Rhinol.*, March 19, 1910.

In a carefully considered monograph M. discusses the various procedures possible as surgical interventions in affections of the jugular bulb, and concludes that it is better when facing this problem not to adhere to any fixed method, but to follow the avenues of infection along their natural route.

GOLDSTEIN.

2435

Sinus-Compression Through Extra-dural Abscess.

A. PASSOW, *Passows Beitr.*, Bd. 3, Heft 1 and 2, 1910.

Report of observations on six cases, in all of which there was caries of the mastoid process extending to the sinus, a perisinus abscess, inflammation of the lateral sinus wall. There was absolutely no blood-circulation in the sinus. The sinus walls touched, and stuck together at their median point. The medial sinus wall was normal. Passow believes that through the pressure of an extradural abscess, the circulation in the sinus can be wholly discontinued, without there having been a previous thrombosis, and without injury to the intima of the sinus. Later on the intima becomes diseased and a thrombosis forms.

2438

Case of Purulent Sinus Thrombosis During a Chronic Suppurative Otitis Media.

SCHMIEGELOW, *Trans. Dan. Oto-Laryngol. Soc.*, 1909-1910.

For a long time it was thought that this was a case of typhoid.

KIAER.

2448**Unilateral Traumatic Paralysis of all the Jugular Foramen Nerves.**

G. WUESTMANN, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61, Heft 1, 1910.

Woman, aged 31, received three blows on the head and one over the left shoulder with a dung-fork. She was then seized by her fascinator and whirled about. Immediately dyspnea, hoarseness, pains in throat and shoulder, dysphagia and a partial paralysis of the left arm.

2444**Diagnosis of Brain Abscess of Otitic Origin.**

L. BAR, *Ann. des Mal. de l'Oreille, du Larynx, du Nez et du Pharynx*, July, 1910; *Bull. de Laryngol. Otol. et Rhinol.*, Oct., 1910, and *Arch. Internat. de Laryngol. d'Otol. et de Rhinol.*, Nov.-Dec., 1910.

All those who have studied brain-abscesses agree that their diagnosis is most difficult to establish. Author presents minute details of a case with a lengthy discussion of the subject.

2447**Anatomy of the Epicranial Aponeurosis and Temporal Fascias.**

G. G. DAVIS, *U. of Pa. Med. Bull.*, Feb., 1910.

Davis finds that effusions beneath the epicranial aponeurosis are limited below as follows: The occipital protuberance, superior curved line of the occiput, mastoid process, top of the ear, upper edge of the zygoma, external angular process and possibly, for a short time, at the upper edge of the orbit, but either at once or in a comparatively short time invade first the upper and then the lower lids. The outer side of the orbit seems to be an especially favorable spot for effusions to gain entrance to the subcutaneous tissues of the lids. The accumulations occurring above the zygoma may either remain above it or possibly, especially if serous, leak through and extend a short distance below. Effusions occurring beneath the pericranium of the parietal region may, as pointed out by Richet, descend toward the temporal region, in which case they pass over the deep temporal aponeurosis.—*Ex.*

2453**Two Cases of Intra-Cranial Acoustic Nerve Tumors.**

JOSEFSON, *Deut. Ztschr. f. Nervenh.*, Bd. 39, Nos. 5 and 6, 1910.

The important question in these cases is the genesis of the tumors. Opinions differ widely. Sometimes the floor of the tumor borders on the petrosa, in which case the tumor must be removed from the side and not as usually from the back.

2455**Value of Schwabach's Test in the Diagnosis of Intra-Cranial Changes.**

HASSLAUER, *Muench. Med. Wchnschr.*, March 1, 1910

Hasslauer considers Schwabach's test, which consists of a comparison of the bone conduction for sound of the patient with that of a normal person, a positive aid in the study of traumatic neuroses.—*Ex.*

2458**Pathology of the Cerebro-Spinal Fluid.**

L. LEDOUX, *Presse Oto-Laryngol. Belge*, Nov., 1910.

A continuation of experiments published in 1908. The author holds that in all endocranial complications of auricular diseases there is some change in the cerebro-spinal fluid. The basis for this theory is minutely discussed as well as the purpose of the changes.

2467**Case of Abscess of Left Temporo-Sphenoidal Lobe.**

A. O. PFINGST.

Original contribution to THE LARYNGOSCOPE, p. 1010, Oct., 1910.

2468**Case of Cerebellar Abscess.**

N. H. PIERCE, *Trans. Chicago L. and O. Soc.*, March 22, 1910.

Abstracted in THE LARYNGOSCOPE, p. 1166, Dec., 1910.

2472**Dangers of Brain-Puncture.**

F. REINKING, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 60, p. 61, 1910.

The author mentions the three instruments, the hollow needle, the scalpel and the dressing-forceps used in exploring the brain and points out in minute detail the dangers involved in their employment.

2475**The Cerebellum and Its Diseases.**

J. S. R. RUSSELL, *Med. Presse and Circular*, March 9, 1910.

Russell says that the various morbid processes by which the cerebrum is affected may be met with also in the cerebellum, but whereas vascular affections are responsible for such a large number of disorders of the cerebrum these play but a small part in the production of diseases of the cerebellum. In consequence tumors supply the most common form of disease of the cerebellum, and about a fifth of the total number of intracranial tumors occur in this region, which is especially liable to be so affected in children. The same general symptoms occur as in the case of all intracranial tumors, but the headache is especially liable to affect the occipital region and to extend down the back of the neck. Vomiting is also a constant symptom.—*Ex.*

2477**Note on Brain-Abscess Formation with Report of Cases.**

S. MACCUEEN SMITH.

Original contribution to THE LARYNGOSCOPE, p. 804, Aug., 1910.

2479**Hemorrhagic Encephalitis and Abscess of Temporal Lobe After Otitis Media.**

F. VOSS, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 61, Heft 3-4, 1910.

The patient was a man aged 50 years. Four weeks previous the mastoid was opened because of a renewed attack of ear inflammation. For three weeks his condition was good until he was seized with nausea, restlessness and drowsiness. Abscess of the temporal lobe and hemorrhagic encephalitis.

2480**Complicated Cerebral Case with Pathological Findings.**

C. F. WELTY.

Original contribution to THE LARYNGOSCOPE, p. 1066, Nov., 1910.

2482**Erysipelas in Conjunction with Mastoiditis.**

A. WIENER, *Med. Rec.*, Oct. 22, 1910.

Wiener reports a case, which is of interest on account of the presence of a mastoiditis during an attack of erysipelas. An operation was urgently demanded. In spite of the fact that such an operation was done within the erysipelatous area, not the slightest disturbance in the way of any serious complication occurred. We are all of us aware of what a treacherous complication erysipelas is in the presence of a wound; how one serious complication after another will attend such an infection. The result goes to show that the idea of an erysipelas exerting a curative effect upon some wounds, as acknowledged by some authors, is not altogether wrong.—*Ex.*

2485**A Case of Influenza Meningitis.**

L. C. AGER and O. T. AVERY, *Arch. of Ped.*, April, 1910.

Male infant, 6 months of age, was brought to clinic on account of a convulsion, followed by slight fever. The child had never been sick before. There had been a slight cough for a few days.

The child was a well developed specimen, weighing twenty-one pounds.

On physical examination, chest was found normal. Abdomen slightly tender everywhere, and a gentle abdominal pressure, both legs were sharply drawn up, giving the appearance of a reflex contracture. There was a slight rigidity and definite tenderness in the back of the neck. Temp. 100.3° F.

Four days later the condition pointed unmistakably to meningitis; head retracted; neck sensitive, slight opisthotonus, pupils sluggish and legs fixed and rigid. Temperature, 103° F., pulse full and regular. The baby had several convulsions each day, had vomited several times, but had retained most of its food, and the stools indicated good digestion.

About 40 c.c. of cerebrospinal fluid were withdrawn under slightly increased pressure. It was not discolored with blood, but was decidedly cloudy. Thirty (30) c.c. of Flexner serum was injected. There was no reaction.

The patient became worse; numerous convulsions appeared; marked hydrocephalus was noticed and the child was comatose part of the time. An attempt was made to relieve the pressure by spinal puncture. No fluid came away but with suction by means of an aspirating needle, only a drop of thick granular white pus was obtained. Death followed after eight days of observation.

On autopsy, the brain and upper cord were only examined. The dura was intensely congested and tense. Brain tissue was very friable. Ventricles so distended that the serum promptly broke through. Two small areas of thick, yellow exudate over upper part of motor zone. Patches of exudate in the sinuses. Both frontal lobes covered wall sides with a thick tenacious green exudate from one-sixteenth to one-eighth of inch thick. It was especially thick below suggesting the cribriform plate as the point of entry of the infection. The ears were normal. The spinal canal, was not opened, but from above it was filled with thick milky pus, not at all the color of the green exudate. Smears and cultures were made by Dr. Avery.

Cultures showed Gram-negative bacilli. Experiments on a rabbit and guinea-pigs, revealed no gross lesions at autopsy, but an organism was recovered in pure culture from two specimens of spinal fluid, whose characteristics compared to those distinctive of bacillus influenzae.

LEDERMAN.

2487

Influenzal Meningitis.

F. E. BATTEN, *Lancet*, June 18, 1910.

Case was first regarded as one of meningococcal infection and treated with anti-meningococcal serum. When the nature of the infection was recognized urotropine was administered with favorable results.

2490

Otitic Meningitis.

L. D. BROSE, *Lancet-Clinic*, June, 1910.

Brose discussed the prognosis and treatment of otitic meningitis. Under treatment he discusses both the symptomatic, such as the application of the ice cap to the head, bromides, codeine, salicylates, iodides and serum, and the operative. Under the head of operative treatment he points out the necessity of early uncovering the diseased mastoid cells, and lumbar puncture between the fourth and fifth lumbar vertebra.

2492

Acute Pneumococcal Meningitis with the Report of a Case Secondary to Empyema of the Frontal Sinus.

CAMPBELL and ROWLAND, *Am. Jour. Med. Sci.*, April, 1910.

Infection of anterior ethmoidal wall from nose through infundibulum and from there through foramen into frontal sinus, a small portion of the posterior wall of the sinus was eroded, and the meninges infected from this point. The author mentions the following characteristics of pneumococcal meningitis: (1) Ninety-nine of all cases are fatal; (2) the

exudate is greenish-yellow and markedly cellular and fibrinous; (3) increase in neuralgia in the subpia and in the cranial nerves; (4) infiltration of the walls of the arteries with leucocytes and exudate.

2494

Otitic Meningitis in Relation of Cholesteatoma of the Ear.

G. DANELON, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Bd. 44, Heft 7, 1910.

One must differentiate between the formation of purulent lepto-meningitis, and acute and chronic suppurations or those due to cholesteatomata. In acute otitis, affection of the leptomeninges is usually a direct result of the suppuration. In cholesteatomata the meningitis is usually complicated with intra-cranial trouble. Therefore, according to Danelon, a case of apparent meningeal origin in which cholesteatoma is present should always be operated for intra-cranial complication. The sinus wall and the exposed dura should also be closely inspected.

2496

Serous Meningitis and Deafness.

H. DE STELLA, *Bull. de Laryngol. Otol. et Rhinol.*, Jan., 1910.

Primary serous meningitis alone, or symptomatological of another infection belongs usually to early childhood. Acute or subacute simple meningitis is clinically determined by the meningitis-syndrome and may be confirmed by the lumbar puncture. These cases often recover completely but sometimes they become complicated often causing partial or total deafness.

2500

Case of Recovery from General Purulent Meningitis.

J. HOLINGER, *Trans. Chicago L. and O. Soc.*, May 17, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 113, Feb., 1911.

2504

Acute Pneumococcic Meningitis.

E. F. McCAMPBELL and G. A. ROWLAND, *Am. Jour. of Med. Sci.*, April, 1910.

Case of man 18 years of age. The symptoms were delirium, incoherent speech, mydriasis toward the right, ptosis toward the right, increased reflexes, hyperesthesia, labial herpes, etc. Lumbar puncture: polynuclear pneumococci. Death. Autopsy: Infection of the ethmoid cells and frontal sinus. Perforation of the cerebral wall of the sinus through which the meningitis spread.

2509

Report of a Case of Tuberculous Meningitis Following Purulent Otitis Media and Complicated by Poliomyelitis and Measles.

W. C. PHILLIPS.

Original contribution to *THE LARYNGOSCOPE*, p. 884, Sept., 1910.

2512**Epistaxis in Cerebrospinal Meningitis.**

L. RIMBAUD, *Med. Press and Circular*, Sept. 7, 1910.

During an epidemic there was epistaxis in four out of twelve cases. In the three first cases the attacks of epistaxis determined an immediate improvement of the symptoms. In the first case the bleeding took place on the second day, and was followed by a sharp fall of the temperature, and on its repetition in the evening the fever fell, the delirium ceased, and recovery was complete in a week. In the second case, the epistaxis did not occur until the fifth day and recurred three times in the twenty-four hours. Here, again, there was marked and immediate improvement, with rapid subsidence of the symptoms of meningitis. Much the same thing occurred in the third case, the disease lasting six days. In the fourth case the effects were not so marked and recovery was delayed for three months.—*Ex.*

2517**Influenzal Meningitis.**

G. SIMON, *Monatschr. f. Kinderh.*, Bd. 9, No. 10, 1910.

Simon reports two cases in previously healthy infants about 8 months old. After a week of cough and fever, suppurative meningitis developed and influenza bacilli were found in the spinal fluid and pus in the cerebral ventricles, joints or middle ear. The primary focus was in the lung in one case and in a joint in another. He tabulates the details of forty-one somewhat similar cases he has found in the literature; thirty-three of the patients were under the age of 2 and 90 per cent under 9. Only 10 per cent recovered, including one woman of 33, two children about 8, and two infants, 9 and 14 months old respectively.—*Ex.*

2521**Two Cases of Meningitis Complicating Middle-Ear Suppuration.**

A. L. TURNER, *Edin. Med. Jour.*, Feb., 1910.

The one was a boy of 13, the other, one of 16 years. In both the discharge had lasted for a long period without symptoms. Turner feels that in these cases as in many others a radical operation was performed at a time when almost all chance of recovery was over.

2523**Ornithodoros Megnini Duges in the External Auditory Canal.**

E. AMBERG, *Arch. f. Ohrenh.*, Vol. 82, p. 273, 1910.

The insect with the above title, commonly known as the spinous ear-tick, infests cattle in Mexico and has occasionally been found in the human ear. It attaches itself to the wall of the canal.

This insect was found to be the cause of tinnitus and pruritus of the canal in a colleague who had been traveling in Mexico. Its removal is best accomplished by means of olive oil.

YANKAUER.

2524**Osteomyelitis of the Temporal Bone.**

E. AMBERG, *N. Y. Med. Jour.*, Sept. 10, 1910.

Male patient, 39 years of age, laborer, had a history of chronic purulent otitis since six months old, following scarlet fever of virulent type.

No specific history. On examination, artificial ear drums were found in both canals, bathed in creamy pus. No tympanic contents were seen. The ear drums had been worn for a year. There was no tenderness over mastoid tip or antrum. Pain was deep-seated, and tenderness was elicited only on movement of auricle or on pressure over tagus and under ext. auditory canal.

Two weeks later symptoms warranted prompt operation. Patient had lost forty or more pounds and condition showed marked invasion of the disease. No chills or elevation of temperature were observed.

On opening the mastoid very little pus was found. The pneumatic cells of the mastoid process were quite obliterated, eburnation having occurred. Difficulty was encountered in entering the antrum, as the bone was ivory-like. Sequestra of bone were removed from the posterior wall of the ext. aud. canal and the necrotic process followed inward for three-quarters of an inch. The disease had involved the major portion of the outer wall of the aditus and antrum.

Three months later, a radical operation was performed on the same side, as suppuration still continued, and the side showed evidences of active disease. Upon opening the old wound, a loose piece of the outer plate of bone, about ten to fifteen mm. was seen. Other sequestra were removed. Previous symptoms of dizzy spells were cured. The author calls attention to the eighteen cell groups in the temporal bone, and the possible extent of such an infection. Also warns against the dangers of the artificial ear drums in suppurating ears. LEDERMAN.

2525

Exhibition of a Specimen; Sequestrum of Entire Petrosa.

T. P. BERENS.

Original contribution to THE LARYNGOSCOPE, p. 87, Jan., 1910.

2526

Development of the Temporal Bone.

G. W. BOOT, *Jour. A. M. A.*, Aug. 13, 1910.

A very interesting series of temporal bones illustrating the development from the infant to the adult, demonstrated at the last meeting of the Section on Otology and Laryngology. The author mentions a number of the features of development. The article presents the evidence of good work done in the fundamental anatomy of the temporal bone.

GOLDSTEIN.

2527

New Roentgen Views of the Temporal Bone in the Living.

H. BUSCH, *Passows Beitr.*, Bd. 3, Heft 6, 1910.

The views are made through the mouth. The lead-glass cylinder is introduced into the mouth of the patient; the photographic plate lies on the occiput of the patient tangent to the cranium, parallel to the transversal plane of the body. A head-rest ensures immobility of head and plate. The head is slightly turned toward the left ear, and tilted a little backwards. Transillumination under the control of the radium-platinum cyanate is made and corrected until the desired view is obtained.

2533**Unusual Case of Otitis of the Temporal Bone.**

G. PIOLTI, *Arch. Ital. di Otol.*, March, 1910.

In connection with this case the author discusses osteomyelitis and otitis of the temporal bone from a clinical and anatomic-pathological standpoint, especially the question of the occurrence of primary otitis of the temporal bone. His case was characterized by: Pain with absence of fever and several symptoms; slow development and course; absence of complications; absence of macroscopic changes at operation; and the presence of streptococci in the pus and granulations.

2540**Cosmetic Treatment of Paralysis of the Facial Nerve.**

H. BUSCH, *Passows Beitr.*, Bd. 3, Heft 5, 1910.

An incision two cm. long is made just beneath the lower edge of the zygoma, to the periosteum, a second of one cm. is made one cm. above and parallel to the angle of the mouth. A thin albuminum-bronze suture is carried from the upper incision through the periosteum under the skin to the anterior angle of the lower cut and back through the posterior angle of the incision. Thus the angle of the mouth may be elevated. The suture is fastened and the skin wounds are united and dressed with collodium. The cosmetic result is claimed to be good.

2541**Mastoid Operation, Simple and Radical Under Local Anesthesia.**

E. W. DAY.

Original contribution to THE LARYNGOSCOPE, p. 108, Feb., 1910.

2542**Treatment of Acute Otitic Meningitis.**

E. B. DENCH, *Am. Jour. of Med. Sci.*, Feb., 1910.

Abstracted in THE LARYNGOSCOPE, p. 823, Aug., 1910.

2544**Method of Opening the Mastoid Antrum Through the External Auditory Meatus as the First Step in the Mastoid Operation.**

S. IGLAUER.

Original communication to THE LARYNGOSCOPE, p. 77, Jan., 1910.

2545**New Operation for Closing Mastoid Wound by Muscle Flap.**

S. IGLAUER, *Lancet-Clinic*, April 16, 1910.

In a child, aged two years, the following operation was performed after the simple mastoid: The original incision was prolonged upward and then forward into the scalp, which was then dissected free from the posterior portion of the underlying temporal muscle. The exposed muscle-tissue with its overlying fascia was then freed from the cranium and split parallel to the muscle-fibers thus forming a muscle flap, with its base under the zygomatic arch. This flap was then rotated downward and backward and was implanted into the mastoid wound, where

it was held in place by catgut sutures fastened to the periosteum at the posterior margin of the wound. A drainage tube was introduced into the antrum and gauze packed around the tube. A counter-opening was made through the scalp over the defect corresponding to the original site of the muscle flap and a small drainage tube introduced here. The original incisions were closed with silkworm gut, except in the region about the drainage tube. The child left the hospital on the twentieth day.—*Ex.*

2546

A Few Important Possible Uses of Electrolysis in the Upper Air Passages in Connection with a Cured Case of Epithelial Cancer of the Base of the Tongue.

R. KAFEMANN, *Deut. Med. Wchnschr.*, June 30, 1910.

Kafemann reports a case of epithelial carcinoma in the nasopharynx of a policeman about 38 years old. The cancer was removed with apparent success but three months later there was a stormy recurrence with numerous metastases in adjoining glands on both sides of the neck. After curetting the growth, it was given electrolytic treatment and rapidly retrogressed under thirteen exposures; there has been no trace of recurrence during the two years since. He applied a current of about 22 milliamperes for 10 or 15 minutes at a time, the sittings at intervals in the course of six months. A suspicious bunch was curetted away twice during the course of electrolytic treatment and the glands in the neck were operated on a month before the last exposure.—*Ex.*

2548

Autopsy-Technic in Endo-Cranial Complications of Suppurative Otitis.

F. MIODOWSKI, *Arch. f. Ohrenh.*, Bd. 82, Heft 1-2, 1910.

M. discusses the practicability of various modifications in the post-mortem technic of the brain differing from the generally accepted method of Virchow. In examining brain abscesses M. makes a series of frontal incisions through the brain. The extensive horizontal section permits the widest field for inspection. If a fistula is found, a frontal section is made through it and its relation to the abscess cavity easily traced. By making parallel cuts to the first frontal cut, the extension of the abscess cavity anteriorly and posteriorly can be determined. Where the brain tissue is unusually soft, M. advises hardening it for several days in a ten per cent formaldehyd before sectioning. Where a microscopic examination and examination of ganglion cells is indicated, alcohol is the hardening fluid; in determining acute processes and making bacteriological examinations, the tissues must be examined while fresh.

In examining the cerebellum, a horizontal cut is made on a level with the posterior border of the cerebrum. In the examination of the cerebellum, a point of especial importance is the locality of the brain-fistula, that is, the avenue of infection that extends from the temporal bone through the dura to the cerebrum. On the posterior surface of the pyramid is the saccus endolymphaticus which has recently sprung into so much prominence by virtue of the pathology of the labyrinth. Where pathological changes are suspected in this area, all damage to these

delicate tissues may be avoided and the entire pyramid and its coverings preserved for examination if a small portion of the cerebellum is allowed to adhere to the membranes at this point when the brain is removed. To examine the sinuses and the jugular bulb, especially when thrombosis is indicated, the dura should not be stripped from the base of the skull but these vessels should be left intact with their bony surroundings as much as possible. Such tissues can then be hardened and microscopically examined section by section. By such modifications as above described a more careful investigation of pathological and pyemic processes extending from the temporal bone is made possible.

GOLDSTEIN.

2550

Sub-periosteal Abscess in the Mastoid Region.

H. MYGIND, *Ugeshr. f. Læger*, p. 1099, 1910.

The author has treated one hundred cases in twenty-five of which—all of them little children—this complication came in the first week of the illness, and in another twenty-five cases a month later. In every case the complication was acute otitis of the mastoid process and very often accompanied by endo-cranial complications; hence it follows that the mortality was very high, nine per cent. Therefore the Wilde incision is not at all indicated.

KIAER.

2556

A Turn-Stool for Examining the Labyrinth; Combination Turn-Stool and Operating Chair.

G. ALEXANDER, *Arch. f. Ohrenh.*, Vol. 83, p. 154, 1910.

The seat of the chair is fixed to a spindle which fits closely into the upright of a heavy cast-iron base. The arms are high, and are connected in front by a horizontal rod at the level of the patient's chest, to prevent his falling out. The back can be lowered and the foot-rest raised to any desired position. A rod attached to the back carries a head-rest, above which is the handle by which the chair is turned. It is made of enameled iron and wood.

YANKAUER.

2558

Improved Rongeur for Mastoid Operations.

W. S. BRYANT, *Jour. A. M. A.*, Aug. 16, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1080, Nov., 1910.

2560

New Apparatus for Testing Hearing.

H. H. GODDARD, *Am. Ann. of Deaf*, Nov., 1910.

An apparatus for testing the hearing has been designed by J. M. McCaillie intended for the use of teachers and others not trained in the accurate examination of the ear and intended for use in the school-room to test the hearing of children. The apparatus consists of the sound-proof box within which a sound is produced by the falling of a small hammer and conveyed to the ear by rubber tubes. The amount of sound passing to the ear is controlled by a graduated wheel. As the sound produced within the box is entirely under control by the slightest move

of the hand of the operator, all incorrect answers on the part of the pupil may immediately be determined. The sound can be switched from one ear into the other or into both ears simultaneously.

This apparatus has the additional advantage that the hearing tests may be carried out in any ordinary room and the results are not influenced by extraneous noises.

GOLDSTEIN.

2562

Revolving Chair Resting on Ball-Bearings for the Making of "Turning" Tests.

S. IGLAUER.

Original contribution to THE LARYNGOSCOPE, p. 760, July, 1910.

2566

Apparatus for Puncture of Labyrinth.

LAFITE-DUPONT, *Gaz. hebd. de Sci. Med. de Bordeaux*, May 15, 1910.

The apparatus is composed of an aspirator and a cannula for paracentesis which enables puncturing the labyrinth and aspirating the fluid through the round window, after the tympanum has been opened. The aspirator is a manometric tube and the paracentesis-cannula has a double curvature so as to enter into the inner tympanum and penetrate into the round fossa.

2568

Gouge for the Removal of the Bony Maxillary Ridge in the Sub-Mucous Septal Operation.

A. BRAUN.

Original contribution to THE LARYNGOSCOPE, p. 472, April, 1910.

2570



Apparatus for Photographing Cavities.

DUNCAN, *Jour. A. M. A.*, Feb. 12, 1910.

2571**An Easily Sterilized Atomizer.**

F. A. FAUGHT, *Jour. A. M. A.*, Jan. 29, 1910.

The accompanying illustration represents an improvement in atomizers, which has developed from a practical knowledge of the shortcomings of the ordinary atomizer as regards surgical cleanliness, this simple instrument being usually a most carelessly used piece of apparatus in the average physician's office.

In an effort to prevent the possible transference of infection by atomizer tips, I have had the old Philadelphia atomizer modified so that the distal portion of the nozzle three and one-half inches is detachable from the



rest of the instrument by means of a screw-thread. This permits ready sterilization by boiling of the one part of the atomizer which usually comes in contact with the patient. To further facilitate the matter, each atomizer is furnished with three tips, which are interchangeable, thus allowing repeated use without the delay incident to sterilization.

While this style of atomizer is not applicable in all cases where atomizers are employed, it is the type commonly used, and so should prove of material aid in minimizing the possible accidental transference of infection.

2572**Eye-Fixation Forceps Used in the Sub-Mucous Resection of the Nasal Septum.**

J. M. FOSTER.

Original contribution to *THE LARYNGOSCOPE*, p. 456, April, 1910.

2580**An Improved Pharyngoscope.**

A. L. BECK, *Med. Rec.*, Sept. 17, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 97, Feb., 1911.

2585**New Spiral Tonsil Tenaculum.**

W. W. CARTER, *Jour. A. M. A.*, April 23, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 770, July, 1910.

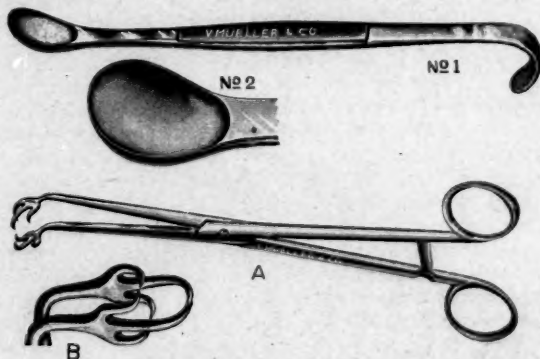
2590**A New Tonsillotome.**W. E. GROUND, *Jour. A. M. A.*, Feb. 26, 1910.**2591****Improved Tonsil Tractors.**

G. C. HALL.

Original contribution to *THE LARYNGOSCOPE*, p. 95, Jan., 1910.**2595****Prevention of Hemorrhage Following Tonsillectomy.**KUTTNER, *Trans. Berl. Laryngol. Soc.*, Dec. 9, 1910.

An instrument of the model of an aneurism needle to ligate the vascular areas en masse instead of tying the individual vessels. The needle is introduced close to the base of the tonsillar capsule, the ligature cannot slip off as it is imbedded in the tissues and hemorrhage is almost impossible.

SAMSON (KUTTNER).

2596**Tonsil Grasping Forceps.**A. M. MACWHINNIE, *N. Y. Med Jour.*, Nov. 19, 1910.**2598****Forceps for Control of Tonsillar Hemorrhage.**

S. ROSENHEIM.

Original contribution to *THE LARYNGOSCOPE*, p. 758, July, 1910.

2599**The Sound Block.**

E. T. SENSENEY, *N. Y. Med. Jour.*, Aug. 6, 1910.

The Sound Block, a modification of the Neumann "Laermapparat," is an adjunct in the functional tests of the ear. Its purpose is to prevent the perception of sound by the ear opposite the one examined—a matter often of great importance in cases of severe unilateral deafness. The principle of the Sound Block is the same as that of the "Laermapparat"; the external canal of the side not tested is closed by an ear piece which at once prevents the direct entrance of sound-waves into the canal and at the same time produces sufficient noise to effectually block the perception of any other sound. The ear pieces of the Sound Block are similar to the watch-type telephone-receivers and are operated by a small portable faradic battery. The instrument seems to the author to possess the following advantages over the "Laermapparat": (1) the ear pieces are more easily approximated to the auricles than those of the Laermapparat to the external canal; (2) the instrument is better adapted to bedside use; (3) there is no danger of electric shock to patient. A. A.

2602**Combined Forceps and Tonsil Separator.**

C. F. WELTY, *Jour. A. M. A.*, Oct. 15, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1113, Dec., 1910.

2603**Antrum Trocar in Situ.**

T. A. DICKSON.

Original contribution to *THE LARYNGOSCOPE*, p. 562, May, 1910.

2605**A New Laryngostroboscope.**

T. FLATAU, *Stimme*, Nov., 1910.

Flatau describes a new model of laryngo-stroboscope in which the motor force is developed by a vertical crank-shaft connected with a small stationary motor. The horizontal part of the apparatus contains the optic system, lenses and lamps. The siren consists of a double disk, one of which contains three, the other two openings in the periphery. These disks rotate on each other in such a way that but the one series of openings is permeable to air. By further rotating of the superimposed disks, two of the openings become permeable to air. By means of the increase in speed produced by the rheostat on the motor, three possible speeds are developed; these are sufficient for tone tests of the entire vocal register.

GOLDSTEIN.

2606**Anesthetic Attachment for the Bronchoscope.**

C. JACKSON.

Original contribution to *THE LARYNGOSCOPE*, p. 153, Feb., 1910.

2608

Holding up of the Epiglottis During Endolaryngeal Treatment.

MERMOD, *Presse Oto-Laryngol. Belge*, Feb., 1910.

The author describes an instrument devised for this purpose which gives satisfactory results.

2609

Instrument for Direct Intubation of the Larynx.

H. P. MOSHER.

Original contribution to *THE LARYNGOSCOPE*, p. 386, Sept., 1910.

2610

Two Laryngeal Forceps.

R. C. MYLES, *Trans. N. Y. Acad. of Med.*, Jan. 10, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 770, July, 1910.

2611

New Apparatus for Laryngeal Intubation.

V. NICOLAI, *Arch. Ital. di Otol., Rinol. e Laringol.*, Jan., 1910.

Apparatus is a modification of the O'Dwyer, but adapted only for the larynx.

2616

Simple and Effective Apparatus for the Administration of Ether and Chloroform Vapor.

C. C. COLLIER.

Original contribution to *THE LARYNGOSCOPE*, p. 1147, Dec., 1910.

2620

The Vacuum Cleaner.

W. H. HASKINS, *Trans. Am. Otol. Soc.*, May 3 and 4, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1080, Nov., 1910.



2617**Simple Air-Compressing Apparatus.**

F. W. DEAN.

Original contribution to THE LARYNGOSCOPE, p. 94, Jan., 1910.

2623**Improved Ether Inhaler and Blood Aspirator.**E. PYNCHON, *Jour. A. M. A.*, May 21, 1910.

Abstracted in THE LARYNGOSCOPE, p. 1101, Nov., 1910.

2626**Preparation for Manufacture of Sterile Paraffin Cylinders.**TRETOT, *Rev. hebdomadaire de Laryngol., d'Otol. et de Rhinol.*, Sept. 17, 1910.

A syringe without a needle is used, whose opening should be of the desired diameter. It thus answers the purpose of a drawing-plate. The syringe is filled with the paraffin at a temperature slightly above the hardening point. Thus cylinders of the desired length and width may be made.

2629**Treatment of Spasmodic Asthma.**H. CAMPBELL, *Clin. Jour.*, Jan. 5, 1910.

Campbell says that all exercise which does not cause unpleasant breathlessness is good. Sudden, violent effort is to be avoided. If the patient is in an asthmatic vein, he must be doubly careful to take his exercise in a cautious and gradual manner. He may find a gradual improvement in his breathing as he proceeds. Walking is the best of all exercises. Respiratory exercises properly carried out are of great service. Massage may be of great help, especially when it is decided to put the patient to bed, as when an exceptionally rigorous dietary is to be enforced. The diet Campbell employs is that recommended by Francis Hare. The quantity of starch, sugar and fat is curtailed, and the patient is fed mainly on animal food. If the weight is supernormal it should be got down to normal; if it is subnormal we should seek to raise it to the normal. As a rule, the constitutionally stout individuals respond more readily to treatment than the constitutionally thin. It sometimes happens that the method of treatment Campbell advocates increases the fat-forming capacity in those in whom it is defective, and he says the more we succeed in this the more successful shall we be in combating the asthmatic tendency. All the patients with asthma treated in this manner have improved; a large proportion have been practically cured.—*Ex.*

2630**Experimental Researches in Nasal Asthma.**

GROSSMANN, *Wr. Med. Wchnschr.*, Nos. 3, 4 and 5, 1910, and *Arch.*

Internat. de Laryngol., d'Otol. et de Rhinol., May-June, 1910.

From numerous experiments on the relation of the circulation and respiration the author concludes that centripetal irritation of the trigeminal and upper laryngeal nerve, contrary to that of any other nerve, interferes with the heart-action. This causes rigidity of the lung, which in turn results in respiratory disturbance. All these disorders are relieved by bisecting the second trigeminal branch or after bilateral bisection of the vagi. From this it appears that the trigeminal nerve is the ascending branch and the vagus nerve the descending branch of a reflex arch. The experimentally obtained reflexes are strikingly similar to those of nasal asthma.

2631**Prolonged Use of Epinephrin in Asthma.**

J. N. HALL, *Jour. A. M. A.*, July 9, 1910.

Hall recommends the use of epinephrin in asthma and reports a case in which prolonged use—for five and a half years—eventually effected a cure. In some instances very serious symptoms developed. He feels these, however, were due to too rapid absorption of the drug, and advises its dilution in a normal saline solution.

2636**Bronchoscopic Treatment of Asthma.**

H. HORN, *Jour. A. M. A.*, Sept. 10, 1910.

The use of bronchoscopy for other purposes than the removal of foreign bodies is comparatively novel. Horn gives a detailed report of a case of bronchial asthma studied and treated by this method, which had been used previously in five cases of the disease reported by Notowny and Galebsky, which are briefly reviewed. In his case there were made five separate bronchoscopies during a period of several months. The work was done in the University Laryngologic Clinic in Bonn, Germany. The case was complicated by hysteria, tuberculosis and severe accessory cavity disease, and the attacks were of great severity. The patient had been obliged to use morphin for years. The first bronchoscopy gave relief by withdrawing an enormous quantity of mucus. The subsequent treatments appeared to give relief, more than the first, through the dilatation and the spraying with cocain employed. The author concludes that the asthma in this case at least was a nervous reflex affection and that cocaine exercises here an effect analogous to its favorable action when applied locally in the nose during an attack of dysmenorrhea. Combining and comparing his results with those of Notowny and Galebsky, he feels justified in drawing the following conclusions: "1. It is possible in a young adult to have an almost complete closure of a main bronchus, due to a tonic cramp. 2. Notowny's conclusion that the theory of bronchial spasm is false is disproved in this case. 3. The complete cures in some cases and the long period of relief in this case seems to indicate that the treatment of spasmodic asthma by the methods elaborated in this paper

is worthy of more extended investigation and should be given a trial when all other methods have proved of no avail. 4. There seems to be no bronchoscopic picture characteristic for an attack of spasmodic asthma. We may have normal mucous membrane, spasms and contractions of the large and small bronchi and redness and swelling, alone or combined in the same case. 5. Tuberculosis, heart disease, slightly scoliotic spine, great weakness and age seem to offer no contra-indication to the use of this method."—*Ex.*

2639

Adrenalin in Acute Asthma.

C. MATTHEWS, *Brit. Med. Jour.*, Feb. 19, 1910.

Matthews has used adrenalin solution in thirteen cases of acute asthma; the results have been immediate relief, lasting for longer or shorter periods. In none of these patients has he observed any undesirable after-effects. The treatment consists of spraying into the nose a solution of adrenalin chlorid varying in strength from one to one thousand to one to four thousand, according to the severity of the case.—*Ex.*

2640

Treatment of Spasmodic Asthma by the Hypodermic Injection of Adrenalin.

B. MELLARD, *Lancet*, May 21, 1910.

Dr. Brian Mellard reports some remarkable results with adrenalin in the treatment of spasmodic asthma. After referring to the use of adrenalin in the form of spray in hay fever and also in hay asthma he describes the marvellous effects of the drug when given by hypodermic injection. He narrates the history of three cases, going into considerable detail, in which the hypodermic injection of adrenalin gave immediate relief, and regularly broke up the spasm whenever it occurred. The dose he employs is from eight to ten minims of the one in one thousand solution injected into the arm. In one of the cases he tried adrenalin solution by the mouth up to fifteen minims, but it had not the slightest effect when given in this way. Apart from the value of Dr. Mellard's article as a contribution to our knowledge of the chemistry and pharmacology of adrenalin, as well as the physiological action of the drug, the paper supplies an instructive and interesting account of the etiology of asthma. It should be consulted in the original.—*Ex.*

2641

Bronchial Asthma as a Phenomenon of Anaphylaxis.

S. J. MELTZER, *Jour. A. M. A.*, Sept. 17, 1910.

Meltzer observes that it is generally agreed that the so-called nervous asthma is due to a stenosis of the bronchioli. It was discovered that the so-called anaphylactic shock is due also to a stenosis of the fine bronchi. The theory is offered that asthma is an anaphylactic phenomenon; that is, that asthmatics are individuals who are "sensitized" to a specific substance and the attack of asthma sets in whenever they are "intoxicated" by that substance. It has been proved that the an-

aphylactic attack is of peripheral and not of central origin. It is therefore suggested that the so-called nervous asthma is also due to a peripheral and not a central cause; in other words, "nervous" asthma is not a neurosis. On account of the capriciousness of the onset and courses of asthmatic attacks, as well as on account of the absence of pathological anatomical changes in this affection, asthma was considered a functional disease and hence a neurosis. He thinks that asthma is still a functional disease but not a neurosis.—*Ex.*

2646

Combined Oxygen-Epinephrin Inhalation Method of Treatment of Bronchial Asthma.

J. SEGEL, *Zntrbl. f. innere Med.*, June 24, 1910.

Segel has an arrangement by which the patient inhales oxygen mixed with one cc. of a one per thousand solution of epinephrin and reports two cases in which these inhalations promptly cured severe bronchial asthma, persisting since early childhood, refractory to all other therapeutic measures. He experimented with it on himself for weeks until convinced that the combined oxygen-epinephrin inhalations were free from any influence on the blood pressure and untoward by-effects.—*Ex.*

2651

O. WEISS, *Therapie der Gegenw.*, Oct., 1910.

Weiss endorses Brugelmann's explanation of asthma as invariably the result of irritation of the respiratory center, and his treatment based on this conception. Brugelmann has had 3,510 patients with asthma during the last thirty years, and has made a special study of the traumatic, reflex and toxic factors that may irritate the respiration center and thus induce asthma in the predisposed. The whole horde of reflexes may act on the respiratory center, reflexes from the eyes, ears, nose, throat, stomach, intestines, sexual organs, cold feet and skin, etc. The toxic action of the insufficiently oxidized blood, as with heart and kidney disease or after excessive exercise, dancing, running, etc., is a prominent factor in the development of the attack of asthma, but the greatest light was thrown on the whole subject by observation of the effect of inhalation of an atropin spray. This frequently arrested at once an attack of asthma, as also painting the nasal mucosa with atropin-cocain solution. The special points where the atropin exerted this action seem to be restricted to the region behind the uvula, the tonsils and their vicinity.—*Ex.*

2660

Can Stammering be Treated Successfully Through the Agency of the Public Schools.

E. L. KENYON, *Jour. A. M. A.*, June 4, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 870, Sept., 1910.

2663

The Cure of Stammering.

G. HUDSON-MAKUEN, *Jour. A. M. A.*, Sept. 3, 1910.

The scientific treatment of stammering must have in view the actual substitution of normal speech for abnormal speech, and its aim primarily therefore, should be not the cure of the stammering, but the development of correct speech. The cure of stammering should be regarded as of secondary consideration, although, of course, it follows as a natural consequence. The stammerer's speech is faulty in every particular. His central as well as his peripheral mechanisms are out of gear and his mental attitude toward speech is wholly wrong. The instrument is out of tune, and the player is unskilled in its use. He cannot retune his instrument and if he could he would be unable to play upon it. The affection, therefore, is a complicated one, involving not only all the various mechanisms of speech, but also some of the higher intellectual and emotional centers of the brain. Indeed, it involves the whole being, and its scientific treatment, therefore, must have for its purpose a thorough re-education of the individual; it must supplant his stammering speech with normal speech; it must make it easier for him to speak freely than to speak hesitatingly; it not only must correct the stammering habit, but it must remove the fear of stammering, upon which much of the trouble depends.

If we correct the habit, without, at the same time, restoring the patient's confidence in himself and in his ability to speak freely, the cure will be only temporary, and if we develop confidence in the patient, by the use of the so-called suggestive method, whether it be given in the hypnotic or waking state, without, at the same time, correcting the physical habits, as is frequently done, the results are only temporary and, of course, unsatisfactory.

It is not unusual to hear of stammering being cured in a few treatments or in a few weeks, but it is quite unusual to hear of such rapid cures being permanent. It is possible in nearly every case by a short-cut suggestive method, to appear to cure stammering, and hence it is that the commercially inclined "stutter-doctor" is able to guarantee a cure and even to promise to refund the money in case of failure. A written guarantee of this sort is nearly always given in these institutes, but no one has ever yet heard of the money being refunded, although it is a fact that only a few of the patients are actually and permanently cured. On the other hand, many of them are often made distinctly worse by their unfortunate experience.

The stammerer must be taught to speak in somewhat the same way as a person is taught to play upon the violin or the piano. The stammerer's instrument, of course, must be put in good condition by the removal of all obstructions to good speech, and then, as in the case of the would-be violinist or pianist, he must be taught to play upon this instrument. The exercises, which are purely educational and physiological, must continue for a sufficient length of time to enable the patient to form entirely new habits of speech, and they must, of course, be adapted to the special requirements of each individual case.

Stammering in the majority of instances, therefore, cannot be cured in a few weeks. On the contrary it often requires several months, or even years, to bring about the desired results. The man who guarantees to cure stammering in six weeks, or indeed who guarantees to cure it at all, is either ignorant of the true nature of the affection or possessed of some ulterior motive, and is, therefore, not to be trusted.—*Ex.*

2665**Congenital Word Blindness as a Cause of Backwardness in School Children.**

E. B. MCCREADY, *Pa. Med. Jour.*, Jan., 1910, and *Va. Med. Semi-Monthly*, Jan. 21, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 559, May, 1910.

2667**Relation of Stuttering to Amusia.**

E. B. MCCREADY, *Jour. A. M. A.*, July 16, 1910.

McCready remarks that while incapable of proof, it is reasonable to suppose that the defective use of the muscles of inspiration, expiration, and of the lips, tongue, and throat, resulting in stuttering is the result of imperfect co-ordination, caused by disconnected and erratic discharges from the cortex. This inco-ordination is between the nervous mechanism controlling the acts of vocalization and articulation and the centers having for their function the appreciation and expression of melody and harmony, and is due to a biological variation in such a center or its commissures. The cure of stuttering is only accomplished by a process of compensation brought about by the education of cells previously nonfunctionating, and by forcing the opposite hemisphere to supply a center similar to that which is imperfectly developed. To this end the reversal of dexterity would seem to be a reasonable procedure.—*Ex.*

2675**Day Schools and Institutional.**

M. E. ADAMS, *Volta Rev.*, Sept., 1910.

The author compares the day-schools and institutional from several view-points. Financially the institutional are, of course, a greater burden to the community; academically they rank about the same; while in modernity of method the day schools have the advantage. Yet the institutional school have long since been teaching trades, a necessity which the day schools are just beginning to recognize. In conclusion the author puts forth some of the present tendencies.

2676**Development of the Hearing.**

J. S. ANDERSON.

Original contribution to *THE LARYNGOSCOPE*, p. 633, June, 1910.

2677**Deaf-Girl's as Hospital Nurses.**

H. ANDERSON, *Volta Rev.*, Nov., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 111, Feb., 1911.

2678**Case of Pure Word-Deafness with Autopsy.**

A. M. BARRETT, *Jour. of Nerv. and Mental Dis.*, Feb., 1910.

Patient showed total deafness for words though speech was retained and the ability to name objects. Post-mortem showed large area of cortex in left first and second convolutions with preservation of the transverse convolutions on the dorsal surface. Pure word-deafness is the result of an anatomical lesion which destroys the fibre relation of receiving station in the transverse convolution of the left hemisphere with the internal geniculate body.

2682**The Wassermann Sero-Reaction in Nervous Deafness and Otosclerosis.**

H. BUSCH, *Passows Beitr.*, Bd. 3, Heft 1 and 2, 1910.

Report of twenty-one cases of nervous deafness and seventeen cases of otosclerosis tested with Wassermann reaction, to show what an important etiological cause lues is, and how necessary it is to make the Wassermann test. Further experiments will prove whether severe anti-luetic treatment can arrest the diseased conditions.

2684**Hysterical Deafness Accompanied by a Peculiar Hysterical Aphonia.**

H. CLAUS, *Passows Beitr.*, Bd. 3, No. 4, 1910.

Sudden attack with severe tinnitus, high grade of deafness, dysakusis, hoarseness, which disappeared on closure of the ears. Of the objective symptoms worthy of note are, shortening of the Schroebach, an overlapping of the left false vocal chord through the superior thyroid-arytenoid cartilage which decreased by closure of the ears, synchronous improvement of the speech. General condition: hyperthesia of the body and the extremities, dermatographia with active reflexes present. Of special mention is a sudden appearance of edema over the right arytenoid cartilage. This case should not be considered as a proof of a changeable action between the ear and voice or speech, although this could be proven experimentally. The author calls attention to the cases of respiratory spasms and attacks of coughing in hyperesthesia acustica, and to those related to the clinical picture of above, hysterical deaf-mutism.—*Ex.*

2685**Post-Traumatic Bilateral Progressive Deafness.**

P. CORNET, *Bull. de Laryngol., Otol. et Rhinol.*, July, 1910.

In two patients who fell on their heads but showed no sign of injury there developed after six or eight weeks an irritation in the labyrinth. After several months the vertigo and subjective noises ceased while the deafness increased. Excluding hysterical deafness or a coincidence of trauma and otosclerosis, the author forms the conclusion—based on one of Manasse's autopsies that in these two cases the trauma caused a fissure in the labyrinthine wall from whence a peristitis developed in the labyrinth.

2688

Development of Speech in the Deaf Child.

A. L. E. CROUTER.

Original contribution to THE LARYNGOSCOPE, p. 642, June, 1910.

2691

The Responsibility of the General Practitioner and the Specialist in the Prevention of Deafness.

F. P. EMERSON, *Boston Med. and Surg. Jour.*, March 17, 1910.

This paper gives the general practitioner the advances which have occurred in otology during the past ten years. It lays stress also on the older and fundamental conditions which are responsible for the pathology of the ear, such as enlarged and diseased tonsils and the pressure of adenoids. Nasal obstruction and sinus disease are given their modern rating as to the important part which they play in causing deafness. The central point of the paper is as follows:—"During the last ten years the science of otology has been revolutionized by the recognition of the fact that the respiratory tract begins at the nose and that the diverticulum, which we call the ear, shares its functional and pathological variations." The writer makes a good point in the following paragraph:—

"In our large cities especially, the children of the poor are looked after infinitely better than those of the well to do. The public schools are being carefully watched, and such children sent to the various hospitals. Here they have the cause of their deafness removed, and not only that but they continue treatment until the hearing has been restored to normal. That the children of our private schools and so-called better class are neglected must be largely the fault of the advice and inefficient treatment of the family physician, who is not alive to the possibilities and the early care and treatment of the middle-ear. I believe that the time is near when all children at stated periods of life will be examined for the prevention of deafness, as they now go to the oculist and dentist, and not wait until their nose has no useful purpose and their hearing has been practically ruined."

The writer continues:—"In early life the middle-ear is made vulnerable almost entirely from adenoids, later there are the infections from the exanthemata, and still less frequently from pneumonia, influenza, etc., but the beginning is a chronic secretory otitis media, which was the result of lymphoid tissue in the vault of the pharynx. As far as the effect on the middle-ear is concerned, it is not necessary to have any obstruction to nasal breathing from adenoids. Small amounts of lymphoid tissue about the tubes will keep up a serous otitis media. In children under four years old we must remember that an acute otitis media may exist without any symptoms of pain. It is the experience of every general practitioner to have seen a child with a sudden rise of temperature, restlessness, and symptoms for which he could not discover a physical cause, although sufficiently severe to make him think of some possible meningal irritation, improve in a few hours following a discharge from the middle-ear. This middle-ear involvement, without symptoms of pain, is very common in broncho-pneumonia, typhoid fever and influenza, and

any complication during the course of these diseases not explained by physical signs should lead us to suspect an acute otitis media.

Doctors McCollom and Borden of the South Department of the Boston City Hospital, in a careful study of the exanthemata, have shown that the middle-ear is involved in ten to fifteen per cent of the cases of scarlet fever: in measles, eighteen to thirty per cent: and in diphtheria, one to five per cent. This is probably high for private practice, where the milder types are observed, but it is instructive in showing the high per cent of otitis media attributed to measles and scarlet fever. In both of these diseases the infection is most active and attended by serious consequences to the hearing function.

It has been shown that in a large number of individuals there is constantly present a chronic rhinitis. This may have been the sequel of some acute infection, but it is kept up by a faulty nasal development which produces an uneven air-current in the nares. This results in an increased functional activity and hypertrophy of the glandular elements, or the original infection has invaded the accessory sinuses, and the confined pus leaks out into the nares, causing a chronic rhinitis, salpingitis and catarrhal or suppurative otitis media, depending upon the activity of the infection.

The faulty septal irregularities, whereby one side of the nares is partially obstructed by its convex surface, ridges or spurs, may date back to trauma in infancy, to imperfect facial development to a high vault, or, as Mosher has pointed out, to irregular eruption of the teeth.

No one operation in the nose is attended with such satisfactory results as the Killian submucous resection of the septum for the correction of these deformities. Not only is all redundant tissue removed but the plane of the septum is left straight on both sides. As the flap is preserved, it is often possible to get primary union. No hard splints are used and no part of the nares has been removed that interferes with its function. This operation is found useful under almost every condition, superseding the cutting and crushing procedures which were so painful. During many acute infections the sinuses are frequently involved. This accounts for the severe headache, particularly in influenza. With a normal nose where the drainage is good and there is no thickened condition of the mucosa about the various openings, this will clear up. But with obstructed nares and hypertrophy, particularly of the middle turbinate, there may result a chronic inflammation and suppuration in the antrum, frontal, sphenoid or ethmoid cells.

Much interest also centers about the use of vaccines, particularly in regard to the pneumococcus and streptococcus infections. These organisms cause an inflammatory action so active and with such consequences to the middle-ear that it is to be hoped that we may see practical results along these lines. At present we must await further developments. The presence of diseased tissue in Rosenmueller's fossae can keep up a chronic suppuration. This is observed daily in every large clinic.

MOSHER.

2692

Phonetic Acoumetry or the Examination of the Auditory Capacity for Articulate Speech.

E. ESCAT, *Arch. internat. de Laryngol. d'Otol. et de Rhinol.*, May-June, 1910 and *Pratique Med.*, No. 10, 1910.

This paper endeavors to determine a standard in the use of the whisper and conversational voice in testing the acuity of hearing.

The value of functional hearing tests by this means is summed up by the author as follows: (1) Where malleus and incus are absent, whisper is heard better than conversation voice. (2) Where there is no stapes, whisper may sometimes be heard at 6 meters. (3) In labyrinthine deafness, conversation voice is heard relatively better than whisper. (4) Deafness for low tones is most marked in affections of the conduction apparatus:—chronic salpingitis, purulent otitis media during suppuration and the cicatricial stage, adhesive processes, ankylosis of the stapes. (5) Deafness for high tones with persistence of low tones is indicative of affections of perception apparatus.

GOLDSTEIN.

2697

Mutes and Deaf-Mutes.

E. FROESCHELS, *Monatschr. f. Ohrenh.*, Bd. 44, Nos. 11 and 12, 1910.

In a series of eleven chapters F. discusses this important problem. The neglect and indifference of the profession to this subject is emphasized. Wernicke's system by which a child is taught and learns language is cited. A systematic description for the examination of speech-defects is described. Stress is laid on the case history.

Deaf-mutes pay close attention to vibrations which occur simultaneously with noises and may confuse the results of the examination if not conducted minutely. The author refers to the symptom originally cited by him that children congenitally deaf or those with acquired deafness following meningitis or suppurative otitis have no tickling sensation in the external auditory canal.

Speech must be classified as speech-comprehension and motor-speech and this again into spontaneous-speech and imitative-speech.

The etiology of infantile deafness is carefully discussed and an exact hearing test is made with the Urbantschitsch harmonica and other instruments with special stress put upon tone-islands.

Another chapter is devoted to the physiology of vocalization, the function of the soft palate and the velts of Passavant, together with a detailed description of the origin of the individual vowels as indicated in the Roentgen pictures of Handek-Froeschel's.

GOLDSTEIN.

2698

Distinctive Diagnosis Between Deaf-Dumbness and Asphasia Without Loss of Hearing.

E. FROESCHELS, *Med. Klinik*, Dec. 25, 1910.

Froeschels says that the normally hearing child is very sensitive to tickling in the ear, while the deaf dumb child is not, and that therefore

the ticklishness in the ear is a distinctively diagnostic characteristic between deaf dumbness and conditions in which there is no power of speech although hearing is unimpaired.—*Ex.*

2699

The Physician and the Deaf Child.

M. A. GOLDSTEIN.

Original contribution to THE LARYNGOSCOPE, p. 624, June, 1910.

2701

Mental Development of the Deaf Child.

E. M. GALLAUDET.

Original contribution to THE LARYNGOSCOPE, p. 636, June, 1910.

2702

Contribution to the Study of the Pathological Anatomy of Deaf-Mutism.

A. A. GRAY, *Jour. of Laryngol. Rhinol. and Otol.*, May, 1910.

The author had the opportunity of examining the temporal bones from four cases of deaf mutism, which when compared and co-ordinated with the facts reported by other observers gave some interesting results. First in respect to the outer and middle-ear, it is noteworthy that no serious defect was found in any of the cases.

In one case however, the middle-ear was rather smaller than the average, but not of an infantile type, for it had undergone development in the usual way with the exception of the persistence of the processus gracilis of the hammer.

With regard to the inner ear, the most salient features of two out of the three specimens examined were the disorganized condition of the organ of Corti, the depression of the membrane of Reissner, the curious development of the stria vascularis in the upper portion of the cochlea, and the degeneration of the nerve elements of the spiral ganglion and the cochlea portion of the auditory nerve.

Passing to the macroscopic appearances, the author lays stress upon the fact that the labyrinths were considerably larger than that of the average normal adults, and larger even than that of the maximum normal human labyrinth. It is to be noted that of the three cases, two occurred in children aged nine and eleven respectively, and in these under normal circumstances the labyrinth would not be as large as in the adult.

The author regards as the probable explanation, the occurrence of increased intra-labyrinthine pressure during fetal or very early post-natal life. At this period the capsule of the labyrinth is surrounded by a layer of cartilage which could yield up pressure in a way that the rigid bony walls of adolescent or adult life could not.

This explanation is borne out by other pathological findings observed.

WELLS.

2703**Progressive Deafness in a Fatal Case of Lues.**

K. GRUENBERG, *Ztschr. f. Ohrenh. u. f. Krankh. der Luftw.*, Bd. 60, p. 260, 1910.

The author found in a man who had died of galloping syphilis and who had suffered from middle-ear and labyrinthine deafness, a chronic perioritis, an exostosis on the left promontory, atrophy of the cortex and of the spinal cord, namely of the basal convolution.

2705**Hereditary Degenerative Deafness.**

V. HAMMERSCHLAG, *Monatschr. f. Ohrenh. u. Laryngo-Rhinol.*, Heft 7, 1910.

After performing innumerable experiments on animals, H. draws the conclusion as stated in the title. He points out that the hereditary laws governing animal and man are similar.

2708**School for the Deaf.**

HARTMANN, *Deut. Med. Wchnschr.*, No. 5, 1910.

Hartmann has established a school for the deaf in Berlin, consisting of six classes. He discusses in detail the method of classifying the degrees of deafness.

2709**Sclerotic Deafness and Re-education of Hearing Through Vocal Phonetic Method of Zund-Burguet.**

J. HELSMOORTEL, *Bull. Acad. roy. de Med. de Belgique*, Feb., 1910.

The author recounts briefly the generally accepted ideas on oto-sclerosis, insisting that without arthritis there is no oto-sclerosis, hence his statement that therapeutic measures are futile and his belief in the voice as the best physical agent to influence the diminished hearing-faculty due to sclerotic degeneration. He makes the following necessary conditions:—(1) The vibrations must reach the ear continuously without being influenced by the breath; (2) the intensity of sound must be sufficiently strong to be felt along the entire aural tract and manifest itself as a tremor or tickling; (3) the amplitude of vibrations must be alike for deep, medium and high tones; (4) the series of tones must extend from the first to the fifth octave. The author mentions his use of a vibrating blade (current of 6 to 8 volts) and a resonator simulating the timbre of the human voice and reports definite amelioration in re-establishing the auditive function. Of twenty-eight cases treated, three were unsuccessful. He concludes with the following:—(a) When oto-sclerosis is hereditary, the earlier the exercises are undertaken, the better is the chance for favorable results; (b) the less advanced the process, the better the results; (c) unilateral is less grave than bilateral sclerosis; (d) when diminution of hearing is regularly progressive from Ut.² to Ut.⁵, prognosis is good; (e) where tone islands for the tuning-fork occur, prognosis should be reserved.

Heredity does not provoke an unfavorable prognosis from the author because due to his conception of the etiology of arthritis, he believes the affection particularly susceptible to this treatment. GOLDSTEIN.

2712

Education and Treatment of the Deaf Child.

R. IMHOFFER, *Oesterreich. Ztschr. f. Kinderschutz u. Jugendfuersorge*, Vol. 2, No. 10, 1910.

Imhofer recommends Urbantschitsch's method of systematic instruction even before the school age. He sanctions the establishment of kindergartens for the deaf child where one could also differentiate between the deaf children and plan their further treatment.

2713

Beethoven's Deafness.

L. JACOBSON, *Deut. Med. Wchnschr.*, July 7, 1910.

The first signs of Beethoven's deafness were noticed about the age of 25 and he tried one method of treatment after another, the deafness growing constantly worse and the subjective sounds—the *Sausen und Brausen*—tormenting him, as he says, like a demon day and night. He turned from one physician to another and finally to quacks, and various ear trumpets were devised to help him, but without benefit, some by Maelzel, inventor of the metronome. He succumbed finally, at the age of 57, to cirrhosis of the liver. The Eustachian tubes were found at autopsy much thickened, with cicatricial depressions near the mouths, the auditory nerves shriveled and without medulla, and general signs of otosclerosis. The convolutions of the brain were twice as deep and numerous as in the average brain, the skull very thick. The loss first of the high tones shows that the deafness was primarily of nervous origin while the subjective sounds revealed the oto-sclerosis which the autopsy findings confirmed. Beethoven had smallpox in youth and a typhoid affection a few years before his deafness; the typhoid, Jacobsohn remarks, may have been responsible both for the otosclerosis and the bowel trouble from which he suffered. There was nothing to suggest syphilis, inherited or acquired, except possibly a circumscribed thickening of the right parietal bone of the skull which, according to the pictures, resembles those observed on a basis of syphilis. The autopsy report was signed by J. Wagner, Vienna, 1827.—*Et.*

2714

The Prophylaxis of Deafness in School Children.

P. JACQUES, *Rev. Hebd. de Laryngol. d'Otol. et de Rhinol.*, Dec. 24, 1910.

The author confirms the statement of Hartmann that a quarter of all school children between the ages of 5 and 15 years, may be considered as being affected with insufficient hearing. Among this large percentage one-fifth have a degree of deafness which places them to a great disadvantage in their studies, and in nearly every case this is without the knowledge of the parents and teachers.

From these statistics the author insists that school children should be regularly and systematically examined for defects of hearing, and the proper means taken to correct the defect, when possible. The children whose hearing can not be improved should be given separate instructions so as to give them the best opportunities for learning.

SCHEPPEGRELL.

2716**Development of Language in the Deaf Child.**

J. W. JONES.

Original contribution to THE LARYNGOSCOPE, p. 653, June, 1910.

2717**What Do the Pathological Changes in the Ear of the Deaf-Mute Teach Us?**S. KANO, *Ztschr. f. Ohrenh. u. f. die Krankh. der Luftw.*, Bd. 61, Heft 1, 1910.

From an examination of fifty deaf-mutes the author concludes that changes usually take place in the cortical organ, while in forty-two per cent changes occurred in the utriculus, and sacculus. This disproves Lucae's theory of sound-perception.

2718**Why and How Slightly-Deaf Persons Ought to Learn Lip-Reading.**M. A. LEGRAND, *Arch. internat. de Laryngol., d'Otol et de Rhinol.*, Jan.-June, 1910.

The author treats the subject in a series of articles and deals especially with the psychic benefits to be derived from lip-reading. He demonstrates by means of exercises his method of instruction and lays great stress upon the fact that lip-reading should be learned by partially deaf patients before all hearing is lost as the remnant of hearing is a great aid in acquiring lip-reading.

He remarks that persons with partial loss of hearing learn lip-reading as readily as those totally deaf and profit more as the stimulation is psychic as well as physical and the exercise encourages and stimulates the remnant of sound which may remain. He insists that the only means of training the partially deaf is by the human voice and not by means of any instrument or vibrating body.

2719**The Deaf Child from the Viewpoint of the Physician and Teacher.**

J. K. LOVE.

Original contribution to THE LARYNGOSCOPE, p. 596, June, 1910.

2720**Physiology and Psychology of Hearing with Special Reference to the Development of Speech.**

G. HUDSON MAKUEN.

Original contribution to THE LARYNGOSCOPE, p. 612, June, 1910.

2721**Bilateral Deafness After Traumatism to the Head.**D. MAYER, *Wr. Klin. Wchnschr.*, April 28, 1910.

Mayor reports the case of a boy, 14 years old, who was kicked by a horse on his right occiput and had his skull fractured, with consequent symptoms of intracranial pressure which were relieved by elevation of the fragments of bone.—*Ex.*

2723**Development of Speech-Reading in the Deaf Child.**

M. McCOWEN.

Original contribution to *THE LARYNGOSCOPE*, p. 661, June, 1910.**2726****Clinical Aspects of Deaf-Mutism.**

F. R. PACKARD.

Original contribution to *THE LARYNGOSCOPE*, p. 618, June, 1910.**2731****The Deaf-Mute.**E. SOOBODA, *Rev. de Med. tech.*, Vol. 2, No. 3, 1910.

Sooboda discusses the responsibility of heredity in deaf-mutism, and also the developmental change in the brain. Under therapy he recommends the use of pilocarpine which acts directly upon the acoustic nerve and often gives good results.

2732**Deafness Due to Lesions in the Brain.**M. A. STARR, *Journal of Nerv. and Mental Dis.*, July, 1910.

Starr reports a case, one of an apoplectic attack characterized by alternating paralysis of motion and of sensation, by dysarthria, and by total deafness in both ears. The patient, whose arteries had become markedly atheromatous, from a long-continued abuse of alcohol, had a slight attack of right hemiplegia and aphasia in the year 1900, when 42 years old. The symptoms rapidly subsided and as the attack was not attended by loss of consciousness, it seemed probably that it was due to a thrombosis in a small vessel, leaving a focus of sclerosis of small extent and without permanent effects.

In June, 1901, a second apoplectic attack, however, occurred, more severe in character, the permanent symptoms of which remained until her death in 1909. In this attack she became unconscious and remained so for two days, after which time it was apparent that the right side of her face and the left arm and leg were paralyzed. Sensation in the right side of the face was markedly impaired to touch, temperature and pain, and the same loss of sensation was apparent in the left arm and left leg and on the left side of the body as high as the collar. In addition to the alternating paralysis and anesthesia, there was a very marked loss of muscular sense in all four extremities, being more marked on the left side. The patient was unable to swallow and choked at any attempt, so that she was fed for a month with difficulty. She was entirely incapable of pronouncing words distinctly and as time went on, this difficulty increased, being intensified by her total deafness. From the day of the attack until her death she was totally deaf in both ears. The deafness was complete for all sounds, high or low, and there was no bone conduction of sound. There was no disease of the ears. This condition was present for eight years. There was apparently no return of hearing whatever.—*Et.*

2736**Relation of Syphilis to Deaf-Mutism.**

E. URBANTSCHITSCH, *Monatsch. f. Ohren. u. Laryngo-Rhinol.*, Bd. 44, Heft 7, 1910.

U. has tested 125 cases of deaf-mutism with the Wassermann serum reaction. The result was: In 86.4 per cent negative or weak results; in 6.4 per cent semi-weak results; in 7.2 per cent positive reaction. The author states, however, that positive luetic cases which have been undergoing specific treatment may give negative reactions and that the per cent of lues is undoubtedly higher than found. He also emphasizes the fact that even in the presence of syphilis this may not be the cause of the deaf-mutism.

A. A.

2739**Detection of Simulated Deafness.**

A. WEISS, *Bull de l'Acad. de Med.*, Oct. 4, 1910.

Weiss calls attention to the discovery by Lombard of the fact that a totally deaf person does not raise his voice in speaking when a loud noise is made close to his ear, while a person with normal hearing does this unconsciously. He uses an electric apparatus which makes a loud noise close to the ear; with normal hearing the person being examined cannot help speaking louder, while the noise is in progress, and this is rendered evident by suddenly shutting off the current, stopping the noise.

—Ex.

2741**Speech Method of Educating the Deaf.**

J. D. WRIGHT, *Am. Educational Rev.*, April, 1910.

This article treats at some length of the methods by which language and lip-reading are taught to the deaf. Special stress is laid upon the necessity of very prompt and intelligent measures to prevent children who have been made deaf between 3 and 8 years of age, from losing their natural speech. The first year after deafness occurs is the critical time in these cases. Parents of these children should at once seek the advice and guidance of some experienced teacher of the deaf.—A. A.

2742**Teaching the Deaf by the Speech-Method.**

J. D. WRIGHT, *Am. Educational Rev.*, Feb., 1910.

This article points out that dumbness is not a necessary accompaniment of congenital deafness, since a totally and congenitally deaf child can be, and very many are, taught to speak with sufficient clearness to be easily understood by all his intimates, and often by total strangers, and at the same time be given an excellent education; that the brain can be trained to comprehend spoken language through the eye when the hearing is lost, and this ability can be made sufficient to meet the most important needs of communication; that the training in speech should be begun as early as the fifth year, and the training in lip-reading may be begun much earlier. The article outlines in some detail the methods employed to obtain the desired results.

A. A.

2743**The Deaf. Their Education, Improvement of Conditions. Responsibilities and Participation of the Profession.**

Original contribution to *THE LARYNGOSCOPE*, p. 1016, Oct., 1910.

2744**New Method of Educating the Deaf.**

J. D. WRIGHT, *Am. Educational Rev.*, Jan., 1910.

The aim of this article is to urge upon the reader six facts:

1. That every deaf child can be taught to speak and to understand when spoken to.
2. That many deaf children are not so taught chiefly because the public, through ignorance, fails to demand it.
3. That a practical working proficiency in speech- and lip-reading cannot be given in the so-called "combined" schools where silent, manual means of communication are employed in and out of the class rooms. The most satisfactory results can only be obtained under purely oral conditions.
4. That the North and East are in advance of the South and West, there being but four small oral schools, containing a total of only seventy-eight pupils west of the Mississippi, and none south of the Mason and Dixon line.
5. That the education of the deaf is no more a charity than any other portion of the public school system.
6. That all educational establishments, and especially the schools for the deaf, should be wholly and forever freed from the taint of political intrigue.

A. A.

2746**Cases of Acquired Deaf-Mutism Due to Congenital Syphilis.**

M. YEARSLEY, *Jour. of Laryngol. Rhinol. and Otol.*, April and May, 1910.

Of five hundred scholars in the deaf centers of the London County Council, the author found two hundred and twenty-five cases of acquired deafness and of these seventeen instances of congenital syphilis.

An exhaustive description of these cases follows. He cites a series of investigators to indicate that from two per cent to eight per cent of acquired deaf-mutism may be attributable to congenital syphilis. These special cases are examined as to the age of onset, family history, teeth, eyes, condition of ears, nose and throat, hearing, speech, tinnitus and vertigo.

GOLDSTEIN.

2748**Duty of the General Practitioner to the Deaf Child.**

M. YEARSLEY, *Brit. Jour. of Children's Dis.*, Aug., 1910.

Yearsley claims that about fifty per cent of the cases of congenital deaf-mutism are the result of consanguineous marriages or of marriages among people themselves deaf or in whose families this defect exists. The physician should emphatically discourage such unions. His duty to the deaf child consists in pointing out the necessity of proper education at an early age.

2749

Radium in Surgery.

R. ABBE, *Arch. of Roentgen Ray*, Feb., 1910.

Abbe reports two cases of papilloma of the larynx and vocal cords, treated by radium. The first case, a woman of 40 years, had had many excisions of the vocal cords for papilloma, by different operators, always with recurrence. He finally cut the thyroid cartilage, excised all trace of the growth, and left a tracheotomy tube below. After several months the tube was removed, but the patient was voiceless and had recurrence of the papilloma. After the liberal use of cocaine, an intra-laryngeal application of radium was made to the growth for one hour. Sixty milligrammes of pure radium sealed in a thin glass tube one inch long, one-eighth inch in diameter was secured to the end of a wire and covered on one side by a lead protective device, the whole being inserted into a celluloid thermometer cover. This gave an exact method of making the application and limiting its effect. Three applications of twenty minutes each at intervals of two months produced a cure, followed by restoration of voice, so that loud conversation in a room or over the telephone was perfectly maintained. This cure was maintained for two years. After long absence the patient again presented herself for an examination, with a small recurrence. He stated that this only proves that the former dosage was not quite sufficient.

The second case was that of a laryngeal papilloma in a woman of 70 years. During a period of forty-five years she had had, half-yearly, excisions of the papillomatous growth. German radium bromide was applied in this case and after a lapse of one year, without other treatment, the papilloma had partly disappeared, giving the patient plenty of room through which to breathe.

In leucoplakia of the tongue and mouth, Dr. Abbe thinks that in radium properly applied we have a long-sought specific. He has seen many patches on the tongue, cheek or roof of the mouth yield to one or several applications and remained cured, when the dosage has been correct.

McCREADY (JACKSON.)

2751

Radium Treatment of Rodent Ulcer, Skin Cancer, Sarcoma, etc.

B. AIKINS, *Can. Prac. and Rev.*, June, 1910.

The writer reviews the work done in Paris by Wickham, and that of the Heidelberg Institute of Cancer Research, and gives the history of three cases of his own—Rodent Ulcer of the Nose, Rodent Ulcer of the Cheek, and Cancer of the Temporo-Malar Region, where complete cure had resulted. These cases are illustrated by cuts.

In case 1, where the wing of the nose was completely destroyed, the radium was used from a flat varnished surface, 8 centimetre, with a radio-activity of 500,000, at intervals for six weeks, the exposures varying from 15 to 30 minutes, and after the first three applications improvement commenced, the discharge became less and pain was absent. In case 3, radium was applied at varying intervals during a period of five weeks, using a flat varnished surface 16 cm. of a radio-activity of 100,000 with lead screens.

WISHART.

2752**Leeches in Air-Passages—Report of Four Cases.**

G. ALAGNA, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, Nov.-Dec., 1910.

The author reports four cases of leeches in the (1) pharynx, removed by means of forceps; (2) in the naso-pharynx, removed by means of forceps; (3) in the larynx, removed after cocaineization with a Mackenzie forceps; (4) in the bronchial tube successfully removed by means of bronchoscopy. Etiology, symptomatology and treatment are described in detail.

GOLDSTEIN.

2755**Chloretone as a Local Sedative to the Respiratory Tract.**

W. S. ANDERSON.

Original contribution to *THE LARYNGOSCOPE*, p. 157, Feb., 1910.

2766**Practical Oto-Rhino-Laryngology. Removal of Foreign Bodies from the Ear, Nose and Pharynx of Infants.**

G. BEREUTER, *Bull. de Laryngol., Otol. et Rhinol.*, Jan., 1910.

The author recommends: (1) Actual determination of the presence of a foreign-body. (2) Never groping about in the dark. (3) In the ear, to use the syringe and in the nose a douche through opposite nostril. (4) In case of obstruction instruments should be used, under general anesthesia in all over six years, and the field should be kept under direct vision.

2770**Death Under Anesthesia Due to Status Lymphaticus.**

E. B. BRADLEY, *Jour. A. M. A.*, May 28, 1910.

Boy of 7, who had previously undergone anesthesia for removal of adenoids and tonsils without any compensations. In the last three years the glands of the left side of the neck had enlarged from the tip of the mastoid to the border of the first rib. There was a provisional diagnosis of gland tuberculosis. The patient took a chloroform-ether anesthesia very well for one and one-quarter hours with the exception of an excessive amount of mucus in the throat. The presence of the winking reflex made it necessary to give a few more whiffs of ether. From this moment on patient did badly. No amount of artificial means suffice to aerate the lungs though the color of the patient was good. Autopsy showed conclusively from slides of the thymus gland a lymphoid hyperplasia.

MYERS (GOLDSTEIN.)

2772**Catching Cold Phobia.**

W. S. BRADY, *Med. Rec.*, Sept. 10, 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 8, Jan., 1911.

2776

Madder as a Coloring Re-agent in Vitam.

G. BRUEHL, *Passows Beitr.*, Bd. 3, Heft 1 and 2, 1910.

In an unusual case of fracture of the humerus, the author had the opportunity to observe the reaction of madder fed to the patient in its coloring effect on the newly-formed callous. The following interesting theory is the basis of this paper:

In the majority of cases of oto-sclerosis the most pronounced changes in bone structure are found on the promontory wall, an area easily accessible to oto-scope inspection. Besides the structural change, this bony tissue also shows an unusual susceptibility to absorb coloring matter. If it were possible to find an especially selective coloring-matter that would color the changed bone structures intra vitam, it might be possible to diagnose otosclerosis at the early stage where tinnitus is found as the only clinical symptom and where some selective therapy might still be exhibited to prevent the threatened stapes ankylosis. Bruehl in using madder, as indicated by Schreiber, is able to demonstrate this coloring of bone tissue in animals in vitam. GOLDSTEIN.

2777

Neuralgia of the Trifacial Nerve. My Experiences with Alcohol-Therapy.

J. S. BRUSKE, *Trans. Nederl. Taudheelk Cong.*, p. 61, 1910.

A true diagnosis of neuralgia of the fifth nerve can only be made after all dental causes have been excluded. The author reports forty cases in which alcohol-injection relieved the neuralgia, and describes the technic. The injection is painful and is followed by an edema which lasts from four days to three weeks. The pain usually disappeared immediately after the injection and is followed by a numbness, although in some cases painful effects resulted which lasted from one to eight days.

2779

Status Lymphaticus in Its Relation to the Use of Anesthesia in Surgery.

D. W. BUXTON, *Lancet*, Aug. 6, 1910.

Status lymphaticus is usually found in children or young people. Their skin is, as a rule, fair, clear and pale. They are self-conscious, easily affected by physical and moral stimulation, highly emotional though they have excellent control over themselves. Their pulse is normally 50 to 60 but is easily accelerated. The thyroid gland is enlarged about fifty per cent and symptoms of exophthalmic goiter are also frequently present, which accounts for some of the sudden deaths during operations on these patients. Adenoid growths, enlarged tonsils, enlarged cervical lymphatic glands, hypertrophied lingual follicles and lymphoid nodules in the sinus pyriformis, anterior surface of the epiglottis and pharyngeal wall are also features. The thymus which is also enlarged may frequently be seen as a pulsating tumor rising above the episternal notch.

2782**Local Anesthesia of the Mucous Membrane with a Solution of Chloro-Hydrate of Quinine and Urea.**

F. CHAVANNE, *Rev. hebdomadaire de Laryngologie, d'Otologie et de Rhinologie*, Sept. 10, 1910.

The author describes the use of the above ingredients applied as a swab to the tonsil, with favorable results, but unsuccessful as an anesthetic when applied to hypertrophied turbinates. By combining these drugs with phenol, menthol and adrenalin:

R. Phenol	grms. 2
Menthol	grms. 2
Quinin. hydrochlorat.	grms. 1½
Adrenalin	millegrams 5

He succeeded in producing a satisfactory anesthetic in such cases where cocaine is contra-indicated.

Urea is omitted because of its tendency to solidify the mixture.

GOLDSTEIN.

2786**Some Ophthalmic Conditions Caused or Influenced by Diseases of the Upper Respiratory Tract.**

A. S. COBBLEDICK, *Brit. Med. Jour.*, May 28, 1910.

After treating this subject from the point of view of the ophthalmologist, Cobbledick warns the rhinologist that blindness resulting from optic atrophy has been caused by intra-nasal operations, that the orbit has been entered while exploring the antrum of Highmore with a trocar or cannula, or boring a hole in the alveolus of the superior maxilla for drainage. Removal of bony spurs from the nose and the middle turbinal bone may produce fracture involving optic canal.

2787**Status-Thymo-Lymphaticus and Its Relation to Sudden Death.**

G. H. COCKS.

Original contribution to THE LARYNGOSCOPE, p. 719, July, 1910.

2788**Reply to Dr. Delavan's Presentation Address.**

J. SOLIS-COHEN.

Original contribution to THE LARYNGOSCOPE, p. 845, Aug., 1910.

2789**Upper-Air Passages in Lepers in the Memel Leper Hospital.**

G. COHN, *Ztschr. f. Laryngol., Rhinol. u. ihre Grenzgeb.*, Bd. 3, Heft 4, 1910.

C. relates a number of interesting facts concerning the Memel leprosy colony. Leprosy has evidently found its way over the German border from Kurland and Kowno. The author is of the opinion that leprosy may be contracted by infection of the upper respiratory tract and offers a substantiation of this theory. The frequency of leprosy infection of the nose and throat is an early symptom of disease. In lepra-tuberosa as in lupus a large series of cases show the initial evidences of the disease in the mucous membrane of the upper respiratory tract rather

than in the skin. The upper respiratory tract is not only the seat of the severest inroads of a leprous infection in the patient but is also the most susceptible area for propagating the infection in others.

GOLDSTEIN.

2792

Etiology of Common Colds.

A. COOLIDGE, *Boston Med. and Surg. Jour.*, July 14, 1910.

that they are directly contagious by sneezing, coughing, close personal contact, towels, etc. The incubation period is from two to four days.

2793

The Influence of the Use of the Automobile Upon the Upper Air Passages.

D. BRYSON DELAVAN, *Med. Record*, Aug. 20, 1910.

Increased atmospheric pressure, when combined with cold, must necessarily exert important influences upon the respiratory organs. In certain pathological conditions, such as emphysema, the risk is obvious. Another injurious factor is the impurities which are inhaled. Disease of the sinuses are aggravated, and serious complications may follow this method of travel, when acute manifestations of such a nature are present.

Patients afflicted with tinnitus aurium should be warned of the baneful influence of the motor car, in such ailments. On the other hand, Dr. Tyson, of Philadelphia, states that some cases of heart disease are markedly benefited by the use of the automobile. In properly selected cases of respiratory troubles, the patients may feel improved owing to increased oxygenation and nutrition.

LEDERMAN.

2794

Presentation Address to Dr. J. Solis-Cohen.

D. B. DELAVAN.

Original contribution to *THE LARYNGOSCOPE*, p. 840, Aug., 1910.

2798

Sero-Anaphylaxis.

DE STELLA, *Arch. internat. de Laryngol., d'Otol. et de Rhinol.*, Jan.-Feb., 1910.

The conditions arising after the injection of antitoxin may be insignificant (eruptions on the skin or mucous membrane) or serious (dysnea, disturbance in blood-pressure, collapse, death). To prevent these the author recommends a dose of serum, i. e., supra-renal extract.

2799

Removal of Foreign Bodies from the Respiratory Tracts by the Aid of the X-Rays.

D'HALLUIN, *Jour. de Sci. Med. de Lille*, April 23, 1910.

Baby girl, 10 months old, in whom a foreign body was located in the right bronchus, by means of the X-ray. Attempt at removal by means of tracheo-bronchoscopy not successful. The body was finally removed with a cutting-forceps under the control of a radiosopic screen. Child died next day from asphyxia produced by the four-days' presence of the foreign body. The author enlarges upon the advantages of this manner of removing foreign bodies.

2800**Respiration. Essay on Respiratory Re-education.**

R. V. D'HEUEQUEVILLE, *These de Paris*, 1910.

Respiratory re-education is indicated in acute and chronic pulmonary affections and in general disease, and is attained through exercise. The results obtained are: Increase in perimeter of thorax, regulation of respiration making it less frequent and fuller, and increase in air capacity.

2801**Mouth-Breathing.**

M. A. DIEMONT, *Dublin Jour. Med. Sci.*, Sept., 1910.

Abstracted in *THE LARYNGOSCOPE*, p. 1048, Nov., 1910.

2804**Enlarged and Indurated Thymus in Boy of Four.**

D'OELSNITZ, *Prat. and Boisscau., Bull. de la Soc. de Ped.*, March 28, 1910.

The right lobe was removed without any improvement in the symptoms, and tracheotomy was performed immediately after. Again there was no improvement, and the manubrium was resected. A fibrous cord running between the two clavicles and preventing the expansion of the subjacent organs was divided. The symptoms disappeared in two days, but death occurred from infection of the mediastinum. The failure of the enucleation was probably due to the leaving of the left lobe.—*Ex.*

2807**Another Case of Scleroma of the Upper Air Passages.**

J. W. DURKEE.

Original contribution to *THE LARYNGOSCOPE*, p. 1132, Dec., 1910.

2810**Advantages of Alypin Anesthesia.**

J. M. FERNANDEZ, *Therapeut. Gaz.*, Jan. 15, 1910.

Fernandez has had so much success with the use of alypin in otolaryngology that he scarcely uses cocain any longer. As an analgesic, he uses a solution of glycerine. In minor operations, such as tonsillectomy, alypin—anesthesia suffices; if combined with adrenalin the effect is intenser and of longer duration.

2811**Improved Methods for the Examination of Sputum and Blood in Relation to Tuberculosis.**

F. T. B. FEST, *N. Mex. Med. Jour.*, Jan., 1910.

Published in the *Interstate Medical Journal*, November, 1909.

2812**Radium in the Treatment of Malignant Growths.**

N. S. FINZI, *Arch. of Roentgen Ray*, March, 1910.

Finzi describes his radium apparatus, his method of application, and gives a table of dosage. He claims that epithelioma of the tongue is

only curable in a very early stage, when it ought to be operated on. Epitheliomata of the floor of the mouth will sometimes respond to larger doses. Epitheliomata of the lips, buccal mucous membrane, palate, pharynx and nose are suitable for radium treatment. Epithelioma of the larynx ought to be treated by filtered radiation in every case. In his opinion in the intrinsic form the delay of a month or six weeks, which is needed to see if there is improvement, will do no harm, as the disease spreads very slowly; while in the extrinsic form everything ought to be tried to avoid laryngectomy. The disease is usually treated from the outside. In carcinoma of the esophagus he claims that this is the only method which holds out any hope. It practically always relieves and he hopes in time to cure some of the cases. The applications are usually made internally by means of an esophagoscope.

McCREADY (JACKSON).

2815

Differential Diagnosis Between Tuberculosis, Carcinoma and Syphilis of the Upper Air-Passages.

B. FRAENKEL, *Charité-Annalen*, Vol. 34, 1910.

Where microscopically and clinically a differential diagnosis of the upper respiratory tract between syphilis, cancer and tuberculosis is uncertain, F. employs various recent diagnostic measures to arrive at definite conclusions. He injects tuberculin sub-cutaneously and observes both the general and local re-action. The Wassermann test when it presents a positive reaction is an evidence of syphilis; a negative reaction however does not preclude syphilis. By reaction with Brieger's anti-trypsin method cancer may be suspected.

Secretions and discharges may be stained for spirochetes and tubercle bacilli. The histological examination of excised portions of tissue is of the greatest importance and care must be taken to include tissue of the tumor proper. The histological diagnosis is not always simple where it depends upon such very small portions of examined tissue.

GOLDSTEIN.

2816

Prognosis of Stenosis of the Upper Air Passages in Children.

J. A. GALDIS, *Bol. de Laringol. Otol. y Rinol.*, March-April, 1910.

In dyspnea the prognosis should be reserved. Often cases which have a very mild beginning, result in the death of the child. Intubation is perfectly safe in dyspnea of diphtheritic origin, for it removes the severest symptom. On the other hand if the dyspnea be caused by sub-glottis, syphilitic, or stridulus laryngitis, etc., intubation is dangerous because it increases the irritation and infiltration.

2819

New Local Anesthetic; Hydrochlorate Quinine and Urea.

GAUDIER, *Presse Med. Belge*, No. 53, 1910.

Thus far the users of this anesthetic have characterized it as harmless, reliable, of long effect, etc. For sub-cutaneous or sub-mucus injection a one cent solution is used; for pencilling a ten to twenty per cent. It

has no vaso-motor properties, but it can be mixed with adrenalin whereupon it attains a vaso-constricting quality similar to, but not as powerful as cocain-adrenalin. Anesthesia is not as rapid as with cocain, nor as intense, but may be prolonged for many hours, and even for days as a hyperesthetic. In sub-cutaneous injections it has this disadvantage that hardening takes place at this point of injection. It seems indicated where much cocain would be necessary and a lengthy anesthesia is required. Theoretically the author believes it of great advantage in tracheo-bronchoscopy when dealing with the less severe cases of foreign bodies.

2820

Increase of Scleroma in East Prussia.

GERBER, *Muench. med. Wchnschr.*, No. 35, 1910.

Gerber calls attention to the increase of scleroma in Germany and reports four cases which he thoroughly discusses. Because of the typical changes in the naso-pharynx he points out that the process usually begins here. If seen in the incipient stage, some cures may be effected by strenuous therapy. Gerber appeals for prophylaxis in regard to this disease.

2822

Scleroma.

GERBER, *Med. Klinik*, No. 7, 1910.

The article is a careful concise study of the diagnosis, course and treatment of scleroma especially rhinoscleroma. Therapy deals only with relief, for a cure has not as yet been found. Ten illustrations accompany the article.

2830

Ascaris Poisoning.

R. GOLDSCHMIDT, *Muench. Med. Wchnschr.*, Sept. 20, 1910.

Goldschmidt relates that he and some of his assistants have attacks resembling hay fever and asthma when they are dissecting and working on ascarides. The peculiar pungent odor of the worms seems to irritate the mucous membrane, even without direct contact with the tissues. The ascaris found in the horse is much more toxic in this respect than the ascaris of man and pigs.—*Ex.*

2832

Method of Examining Sputa for Tubercle Bacilli.

E. H. GOODMAN, *N. Y. Med. Jour.*, July 2, 1910.

The solution which Goodman uses is really Labarraque's solution, except that instead of 75 grams chlorinated lime, 150 grams are used, and in addition a solution of 3 per cent sodium hydroxid. It is to the action of the chlorin and the sodium that its dissolving properties are ascribed. To the sputum is added an equal amount of the solution. The whole is thoroughly mixed with a glass rod, and put on a boiling water bath. After the sputum has become a homogeneous mass (from fifteen to twenty minutes) it is removed from the water bath, a small amount of water added, and the whole is centrifugated for five minutes in an electrically driven centrifuge. If more than one tube is used the supernatant fluid is poured off and the sediments combined, washed in the centrifuge with

physiologic salt solution for three to five minutes, the excess poured off, and the residue smeared on a slip by means of a platinum loop. The specimens were stained in the usual manner. Apart from avoiding the necessity of using a patented substance the new solution has the advantage of being about one-fourth as expensive as the former. It is easily made in any laboratory, and where facilities do not permit of this, it may be made by a druggist.—*Ex.*

2835

Employment of Pergenol Pastils Especially for Children.

M. GOTTHILF, *Med. Klinik*, No. 8, 1910.

The author recommends the use of pergenol pastils for children instead of a gargle. Infants should get half a pastil dissolved in milk or fennel-tea.

2839

Parathyroids and Sudden Death in Children.

P. GROSSER and R. BETKE, *Muench. med. Wchnschr.*, Oct. 4, 1910.

Grosser and Betke state that when no other explanation for the sudden death of a child can be discovered, the parathyroids should be examined with the microscope. It may be possible to discover in them traces of a destructive process involving the larger part of their substance and this alone is sufficient to account for the fatality, as he shows by reports of three cases and a case previously reported by Yanase. The children were only 2 or 3 months old and death occurred suddenly in apparent health except for a mild bronchitis in one case. Aside from the destructive process in the parathyroids, the necropsy findings were normal.—*Ex.*

2843

Measurement of Volume of Respiration.

H. GUTZMANN, *Med. Klinik*, No. 24, 1910.

Instrument by which the respiratory-volume in speech and song may be measured. He feels this instrument will be of use in respiratory diseases and emphasizes the importance of considering the volume of respiration in these diseases.

2849

Relapsing Influenza.

W. HELLPACH, *Deut. Med. Wchnschr.*, March 18 and 25, 1910.

Hellpach applies this term to the form of influenza in which the infection assumes a chronic, afebrile, relapsing character, the nervous system being predominantly affected. He describes a number of typical examples and discusses treatment and prophylaxis. The depression is generally out of all proportion to the severity of the symptoms, the patient finds mental work difficult and there is frequently a tendency to stumble over certain syllables—a difficulty in finding the right word. A tendency to dizziness is often observed, as also intolerance of alcohol, disturbances in the sexual sphere, motor weakness, sensory disturbances, muscular twitchings, and secretory, trophic and vasomotor phenomena, in addition to the typical neuralgiform pains in the feet and hands and

elsewhere. It is significant that bacteriologic examination recently has revealed pyogenic germs in association with the specific influenza germ in many cases. This relapsing influenza includes certain phenomena which suggest septic trouble.—*Ex.*

2852

Endonasal Method of Removal of Hypophyseal Tumors.

O. HIRSCH, *Jour. A. M. A.*, Aug. 27, 1910, and *W. Med. Wchnschr.*, No. 13, 1910.

Hirsch describes his method of removing tumors of pituitary body through the nose, and reports cases. His technic is as follows: The mucous membrane of both sides of the nasal septum is cocaineized with a 20 per cent cocaine solution and infiltrated in its entire extent with Schleich solution. An incision is made along the anterior edge of the quadrangular cartilage, through the mucous membrane of one side, down to the cartilage, and the mucous membrane is raised by a raspatorium, together with perichondrium and periosteum, from the cartilage and bone. The cartilage is incised 0.5 cm. from the original incision and a raspatorium slipped between the perichondrium and the cartilage and carried to the posterior border of the septum; the mucous membrane, together with perichondrium and periosteum, are now raised from cartilage and bone on this side. The membranes are now held apart by a nasal speculum and in this way a medial nasal cavity formed in which one sees the bare cartilage. This is removed with one sweep of the cartilage knife and the vomer and the perpendicular plate of the ethmoid are resected with the aid of a bone forceps. Up to this point this operation is identical with Killian's submucous septum-resection. To bare the anterior wall of the sphenoidal cavity it is necessary that the mucous membrane of the vomer where it joins the sphenoid be also separated from the bone. This is very easily done, after which the mucous membrane is separated from the anterior surface of the sphenoid on both sides as far as the ostium sphenoidale, so that the raspatorium falls into the sphenoidal cavity. Now, through this sack of mucous membrane one removes posterior part of the vomer and the rostrum sphenoidale with the bone forceps, and with several strokes of a chisel one breaks through the anterior wall of the sphenoidal cavity and after removing the sphenoidal septum one sees the hypophyseal prominence in its entirety. After opening the sella turcica and the dura and incising the hypophysis, the hypophyseal tumor is found in the sphenoidal cavity.—*Ex.*

2866

Alypin a New Local Anesthetic.

IMPENS, *Clinique*, No. 2, 1910.

Alypin is soluble in water, it is as strong but not as toxic as cocaine. It is of especial value in ophthalmology.

2875

Surgical Mistakes in Children.

S. W. KELLEY, *Jour. A. M. A.*, Sept. 3, 1910.

Kelley calls attention to the necessity for caution when operating on children, and gives examples, coming under his observation or to his

knowledge of fatalities from unexpected hemorrhage and bad effects from operations performed when unsuspected or overlooked disease like rhinitis, whooping cough or pharyngitis existed. It is a mistake to perform an operation on a child when a fever temperature indicates the possible onset of an acute disease. A case of the bad effects of neglect to promptly remove foreign bodies from the larynx is reported. There is no safety until such are removed. Mistakes of diagnosis in children are not uncommon. Many a case of retro-pharyngeal abscess has been mistaken for tonsillitis, and he reports a case in which it was taken for uremia. Other instances of diseases liable to cause mistakes are mentioned, such as empyema, intussusception and appendicitis diagnosed instead of pneumonia. The article is full of striking instances, too numerous to be given in an abstract, of diagnostic and surgical mistakes in treating children. Many conditions are present in the child which never or seldom occur in the adult, and it is a great mistake to consider that we can be guided by the surgery of adults in the surgical treatment of children.—*Ex.*

2883

Threatening Incidents in the Use of Menthol-Preparations in Infancy.

W. KOCH, *Muench. Med. Wchnschr.*, No. 37, 1910.

The author reports a case of laryngeal spasm in an infant of three weeks, which lasted for a long time and was caused by penciling the nose with coryfin.

2884

Relative Benignancy of Some Sarcomata and Carcinomata.

KOSCHIER, *Wr. Klin. Wchnschr.*, No. 17, 1910.

From a prognostic view-point, besides considering the age of the patient and the etiology and position of the tumor, one should recognize the importance of the resistance of the organism and the virulence of the tumor.

2900

Direct Visual Inspection of Upper-Air Passages.

E. MEYER, *Berl. Klin. Wchnschr.*, April 11, 1910.

The author discourses on the advantages and uses of bronchoscopy. He mentioned as one of its chief uses the removal of foreign bodies. Bronchoscopy could and should be learned by the general practitioner; thus aiding him in his clinical work.

2908

Technic of Photo-therapy in Rhino-Laryngology.

A. NEPVEU, *Bull. de Laryngol. Otol. et Rhinol.*, Oct., 1910.

After discussing the various modifications of helio-therapy as employed by many authors and pointing out the futility of this form of photo-therapy because of the deficiency of actinic rays and intensity of light, the author describes very minutely his technic in the use of an automatically adjusted electric arc-lamp varying from 1 to 15 amperes and 75 to 80 volts. He reports a number of satisfactorily treated cases of tuberculous ulceration of the larynx, paraesthesia of the pharynx, glossitis and ulceration of the nasal septum.

GOLDSTEIN.

2920

Case of Sub-Cutaneous Surgical Emphysema. Another Unusual Complication Following the Removal of Faucial Tonsils.

B. D. PARISH.

Original contribution to THE LARYNGOSCOPE, p. 1046, Nov., 1910.

2929

Hysteria of the Upper Air Passages.

D. A. POPOVICI, *Arch. f. Laryngol. u. Rhinol.*, Vol. 23, p. 153, 1910.

These severe symptoms were overcome by cauterization during esophagosecopy.

2932

Serum Treatment of Hemophilia.

A. J. PATEK, *Wis. Med. Jour.*, Nov., 1910.

The etiology of the disease is still shrouded in mystery, but it is probable that in hemophiliacs the clothing ferment is absent, deficient or held in abeyance. Human or animal blood serum applied locally, subcutaneously or intravenously may have a styptic action during hemorrhage. But owing to the danger of anaphylaxis when alien serum is used, human serum is preferable. A prophylactic injection of serum prior to operation is advisable in these cases. Subcutaneous injections are preferable in most cases. Transfusion may be employed in massive hemorrhage.—*Ex.*

2938

Deaths Under Scopolamin-Morphin Anesthesia.

RINNE, *Deut. Med. Wchnschr.*, Jan. 20, 1910.

Rinne's experience confirmed the advantages of this method of preparing the patient for an operation until two fatalities within three days warned him of its dangers. The cardio-vascular system in these fatal cases was below par, and henceforth he will use a smaller dosage in such cases.—*Ex.*

2943

The Medical Uses of Radium.

G. STERLING RYERSON, *Can. Lancet*, Sept., 1910.

The author records a few of the facts regarding the origin and properties of radium by way of introduction, and then relates his experience in treating a recurrent wart of the nose, which had been twice excised. A small amount of pure radium was pressed against the wart, screened by a thin layer of aluminum. In a few days a slight hyperemic zone appeared around the growth, accompanied by tenderness and itching. In the next ten days these symptoms increased, and during the third period of ten days, the growth rapidly receded.

A leucoplakia of the roof of the mouth disappeared in three, thirty minute applications.

The strength of the radium used, the length of time of application, the amount of filtration necessary to a given case, and the intervals between treatments all require careful consideration and experience.

WISHART.

2946**Case of Werlhoff's Disease.**

SCHLEIPSTEIN, *Medycyna*, No. 12, 1910.

Man, vegetarian, in whose mouth and naso-pharynx bloody suggillations become apparent at intervals. This condition has existed for the last eight years. Schleipstein diagnosed the case as one of Werlhoff's disease.

2948**Application of Cold Inhalers for Diseases of the Upper Air Passages.**

A. SCHOENEMANN, *Arch. internat. de Laryngol. d'Otol. et de Rhinol.*, March-April, 1910.

The author strongly recommends this therapy, especially in rhinopharyngitis.

2950**Hot Baths in Whooping Cough.**

T. SCHROHE, *Therap. der Gegenw.*, Sept., 1910.

Schrohe has always witnessed great relief follow a hot bath given toward evening. The water should be about 99° F. and the child should stay in the bath for from ten to fifteen minutes, the head being kept cool with a cold water compress. The children sleep well after it, and the number and severity of the paroxysms seem much diminished. He has noticed that the skin of children with pertussis is pale and cool, indicating contraction of the vessels in the skin; the hot bath counteracts this, and thus relieves the internal organs, promotes elimination of toxins and soothes the nervous system and the tendency to the paroxysms.—*Ex.*

2953**Treatment of Cancer by Radio-therapy and Radium.**

J. H. SEQUEIRA, *Arch. of Roentgen Ray*, Aug., 1910.

Sequeira considers carcinoma occurring in different parts of the body, but states that epithelioma of the lips, of the floor of the mouth, tongue, pharynx and jaw, have been little influenced by the X-ray. There has been relief of pain, and ulcerated areas have cleared in some measures, but the early involvement of glands in these cases renders the X-ray merely palliative.

He cites one case of epithelioma of the ear in which a very extensive operation was performed, with removal of the auricle and a large part of the temporal bone. The application of the X-ray was made to the cavity. The patient recovered and there has been no recurrence up to date—a year after operation.

MCCREADY (JACKSON).

2963**Alypine in Oto-Rhino-Laryngology.**

A. STAURENGHI, *Arch. ital. di Otol. Rinol. e Laringol.*, March, 1910.

The author relates his experiments with alypine as an anesthetic and concludes that it presents important advantages over cocaine in that: it can be sterilized by boiling; it is a thorough anesthetic; it has no ischemic effect—so that the surgeon may produce this effect by adding adrenalin. Alypin is, further, not at all toxic or dangerous. LASAGNA.

2966**Thymus Treatment of Carcinoma.**

Y. TAKAI, *Sei-i-Kwai Med. Jour.*, Sept. 30, 1910.

Report of five cases of inoperable carcinoma treated successfully with dried thymus gland. Takai found that the course of the disease was lightened and the final end made more comfortable.

2972**Argyri After Penciling with Lapis.**

K. THUE, *Norsk Mag. f. Laegevidenskaben*, p. 360, 1910.

During many years an old man had penciled himself in the mouth, and thus developed a local silver dermatitis as well as a universal dermatitis.

KIAER.

2978**Thymectomy.**

V. VEAU and E. OLIVER, *Presse Med.*, April 9, 1910.

Veau and Olivier give an illustrated description of their technic for subtotal subcapsular thymectomy for hypertrophy of the thymus. They have performed the operation in four cases to date, and this experience, with the cases in the literature, confirm, they state, the facility, the harmless and the good results of thymectomy. The questions still pressing for solution are; how can hypertrophy of the thymus be recognized? and, what are the operative indications?—*Ex.*

2982**New and Simple Method of Performing Wassermann's Test for the Diagnosis of Syphilis.**

R. WEISS, *Pacific Med. Jour.*, Aug., 1910.

Because of the complexity of the Wassermann test Dungern indicated an improvement in the technic which requires little skill and time. The author has devised a case to hold the various elements necessary for the test. In his article he details the technic.

2983**Relations Between Status Lymphaticus and Addison's Disease.**

F. V. WERDT, *Berl. klin. Wchnschr.*, Dec. 26, 1910.

In v. Werdt's two cases pronounced hypoplasia of the chromaffine system accompanied the typical Addison's disease, while the lymph glands were enlarged.—*Ex.*

2984**Surgery of the Hypophysis from the Standpoint of the Rhinologist.**

J. M. WEST, *Arch. f. Laryngol. u. Rhinol.*, Bd. 23, p. 288, 1910.

To prevent the dangerous intra-cranial and the deforming extra-cranial methods, West sought for an intra-nasal means of approach and worked out a method. Both middle turbinates are removed and both sphenoid sinuses opened. A parallelogram is measured on the septum which leads directly to the sphenoid sinus septum, which is also removed. Then the sella turcica is opened.

2996

Diseases of the Nose, Mouth, Pharynx and Larynx.

A. BRUCK.

Reviewed in THE LARYNGOSCOPE, p. 929, Sept., 1910.

2997

Direct Laryngoscopy, Bronchoscopy and Esophagoscopy.

W. BRUENING.

Reviewed in THE LARYNGOSCOPE, p. 144, Feb., 1911.

2998

Teachers of Diseases of the Nose, Pharynx and Larynx in Paris in the Pre-Specialistic Period.

C. CHAUVEAU.

Reviewed in THE LARYNGOSCOPE, p. 929, Sept., 1910.

3000

Nursing in Diseases of the Eye, Ear, Nose and Throat. Committee on Nurses of the Manhattan Eye, Ear, Nose and Throat Hospital.

Reviewed in THE LARYNGOSCOPE, p. 143, Feb., 1911.

3003

Hints for the General Practitioner in Rhinology and Laryngology.

J. FEIN.

Reviewed in THE LARYNGOSCOPE, p. 143, Feb., 1911.

3005

Etiological Relation of the Nose and the Genital Organs.

W. FLIESS.

Reviewed in THE LARYNGOSCOPE, p. 141, Feb., 1911.

3007

Diagnosis and Treatment of the Nose.

GAREL.

Reviewed in THE LARYNGOSCOPE, p. 513, April, 1910.

3009

Syphilis of the Nose, Throat and Ear.

P. H. GERBER.

Reviewed in THE LARYNGOSCOPE, p. 929, Sept., 1910.

3010

Manual on Diseases of the Nose, Throat and Ear.

E. B. GLEASON.

Reviewed in THE LARYNGOSCOPE, p. 142, Feb., 1911.

3011

The Ear and its Diseases.

A. A. GRAY.

Reviewed in THE LARYNGOSCOPE, p. 142, Feb., 1911.

3012

Treatise on Diseases of the Esophagus.

GUISEZ.

Reviewed in THE LARYNGOSCOPE, p. 143, Feb., 1911.

3015

Hand-Book of Diseases of the Ear.

R. LAKE.

Reviewed in THE LARYNGOSCOPE, p. 927, Sept., 1910.

3017

Suppurations in the Middle-Ear and the Accessory Cavities of the Nasal Fossae and Their Complications.

LUC.

Reviewed in THE LARYNGOSCOPE, p. 927, Sept., 1910.

3019

Asthma and its Treatment.

M. SAENGER.

Reviewed in THE LARYNGOSCOPE, p. 141, Feb., 1911.

3021

Diseases of the Nose and Throat.

H. TILLEY.

Reviewed in THE LARYNGOSCOPE, p. 142, Feb., 1911.

3022

Text-Book on Otology.

V. URBANTSCHITSCH.

Reviewed in THE LARYNGOSCOPE, p. 141, Feb., 1911.

3025

Rhinology. A Text-Book on Diseases of the Nose and the Nasal Accessory Sinuses.

P. W. WILLIAMS.

Reviewed in THE LARYNGOSCOPE, p. 928, Sept., 1910.

3027

Diseases of the Nose and Naso-Pharynx, with Special Reference to Rhinological Propedeutics.

C. ZARNIKO.

Reviewed in THE LARYNGOSCOPE, p. 572, April, 1910.

3028

Poisoning Resulting from the Inhalation of Castor Pomace.

S. B. GILBERT, *Yale Med. Jour.*, Dec., 1910.

In an interesting paper presented by Gilbert, McFarland cites several cases of "Poisoning Resulting from the Inhalation of Castor Pomace." This is the dry material left after expressing the oil from castor beans. Castor beans contain ricin, one of the most powerful poisons known, one ten-thousandth of a milligram of which injected into the circulation of

a rabbit produces death. Castor pomace is used as an ingredient in most fertilizers, because it contains so much nitrogen.

Case 1. A man ground some pomace in a coffee grinder, and inhaled a large quantity of dust, also getting some in his eyes. In describing the effect of the pomace dust the man said: "My voice changed at once, becoming very much deeper and very hoarse. Sneezing began at the same time and was very persistent. In ten minutes, my eyes had swollen so that I was sure that I was going to lose them. They were most unsightly and very red. They were not very painful after the swelling had reached the maximum, and the sight was not impaired. The cough lasted six months." There were eight repetitions of this experience.

Case 2. Though handling "hundreds of fish without any inconvenience whatever," in this instance, on opening a sample can of dry ground fish, the patient began at once to sneeze. Inquiry elicited the information that the grinder in which this sample of fish had been ground, had been used just previously for grinding pomace, and "the grinder had been cleaned before grinding the fish."

Case 3. "Olds & Whipple, of Hartford, who handle a good deal of pomace, had about twenty tons of it stored on the fourth floor of their building. One day a gentleman came into their store on the first floor and was immediately taken with symptoms of pomace poisoning. He had a coughing fit accompanied with a swelling of the membranes of the throat, and the proprietor of the store thought he would die before he could be got out of the building. The slight amount of pomace dust, which must have been in the air of the store, was probably responsible for the trouble.

Case 4. Some potatoes were sent to a farmer from a neighbor's. This farmer was known to be susceptible to pomace poisoning. The only suitable receptacle available was a pomace bag. So this was washed and the potatoes sent in it. "The whole family were affected with pomace poisoning."

Case 5. "Some old lumber, used in the fertilizer factory in Hartford, was sent up to the house of the owners of the factory to be used as kindling. It was split up in the cellar. An old lady in the house was immediately taken sick, and finally had to leave the house."

In summing up these cases, the author adds: "My experience has been such that I have no trouble in believing all of these reports to be true. When these fertilizers containing castor pomace in only a minute degree are spread over the surface of the ground, while in a dry state, they must irritate the nose and throat of the workmen and even of others passing the fields. We may have here a potent cause of nasal and ocular troubles, the causes of which puzzle the doctors."

MOSHER.

3029

Acute Infections of the Upper Respiratory Tract in Children.

C. G. KERLEY, *Yale Med. Jour.*, July, 1910.

Kerley states that there are three classes of infection which generally localize themselves as follows: The staphylococcus and pneumococcus is usually found in affections of the nose, the streptococcus and B. Klebs-

Loeffler in those of the throat, and the B. influenzae in those of the trachea. Tuberculosis of the upper respiratory tract is not frequent in children. Enlarged tonsils and adenoids seem to be correlated with a lack of resistance. In this way a great deal of the otitis media of the young may be explained.

MOSHER.

3030

The Ideal Nose and Pharynx.

F. M. WILSON, *Yale Med. Jour.*, Aug., 1910.

Wilson discusses the interdependence of ear, nose, and throat conditions. He considers the deleterious consequences of obstruction to normal breathing under two headings: (a) Obstruction in the nose causes a so-called negative pressure in the pharynx, and vice-versa. Consequent local stasis and congestion tends to hypertrophy and we get the enlargement of turbinate, adenoid, and tonsil, in a recurring vicious circle. On account of this interdependence, the remedying of one condition alone will frequently not relieve the condition. (b) Even slight respiratory obstruction means in the long run, considerably less fresh air to the lungs. This diminution of air supply may be an important etiological factor in disease, and the correction may do much toward establishing a cure where the disease has gained a foothold. Tuberculosis is sighted as an example.

The author calls attention to the many possible folds and pockets in the upper respiratory tract, which though they may not obstruct breathing, serve as a harbor for secretions to lodge in and in which germs multiply. These infected foci then become intermittent sources of disease.

He concludes as follows:—The "ideal" nose and pharynx permit of free but not too much breathing. Their mucous membrane surfaces should be as smooth as possible and should not contain folds and pockets which may serve as infective foci.

MOSHER.

